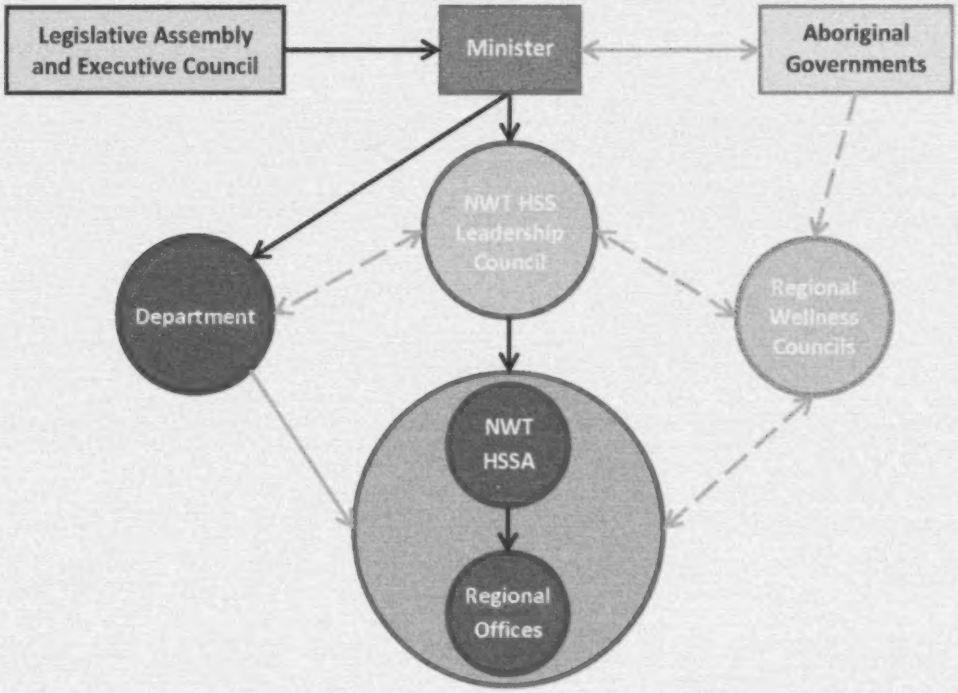
HEALTH AND SOCIAL SERVICES
2015-16 Business Plans

1. DEPARTMENTAL OVERVIEW

Making Improvements to Our System

The 2015/2016 fiscal year will be a year of significant change for the Northwest Territories (NWT) Health and Social Services System as we transition to operating as a single integrated system. This new approach will improve the delivery of health and social services to NWT residents, allow us to better utilize our resources and expertise, and ensure the ongoing sustainability of the Health and Social Services System.



The proposed structure will see existing health and social services authorities amalgamated into one Territorial Authority with one governance board - the NWT Health and Social Services Leadership Council (NWT HSSLC). Regional Wellness Councils will play an advisory role. The structure of local and regional service delivery will remain largely unchanged, although job descriptions and reporting relationships will change; and over time new service delivery arrangements will evolve.

Under this structure, the NWT HSSLC will be accountable to the Minister of Health and Social Services and serve as a board of management for the delivery of health and social services across the NWT. The NWT HSSLC will be mandated to deal with risk management, quality assurance, budgeting and other complex issues, which will allow Regional Wellness Councils to focus on the issues of greatest concern to their communities, and advocate for these issues to the NWT HSSLC.

Regional Wellness Councils will play an important role in providing advice on local and regional program and service delivery, in addressing local concerns and priorities, and in supporting cultural competence and culturally appropriate programming.

The role of the NWT Health and Social Services Authority (Territorial Authority) will be to coordinate operations across the territories, which will include:

- Delivery of acute care;
- Clinical leadership (physicians, nurses, social programs);
- Design and monitoring of programs for regional service delivery;
- Delivery of territorial programs (Medical Travel, Med-Response, Information Systems Service Centre, Lab Services, Digital Imagery and EMR); and
- Budgeting and procurement.

Corporate services, duplicated among the eight authorities, will be coordinated through the Territorial Authority. This includes services such as finance and accounting, purchasing, information systems and recruitment. This will increase efficiency and help to address capacity challenges within the system.

The Department's role will shift focus to more ministry type functions with limited direct program delivery. Functions will include developing policy and legislation, standards development, and monitoring and reporting.

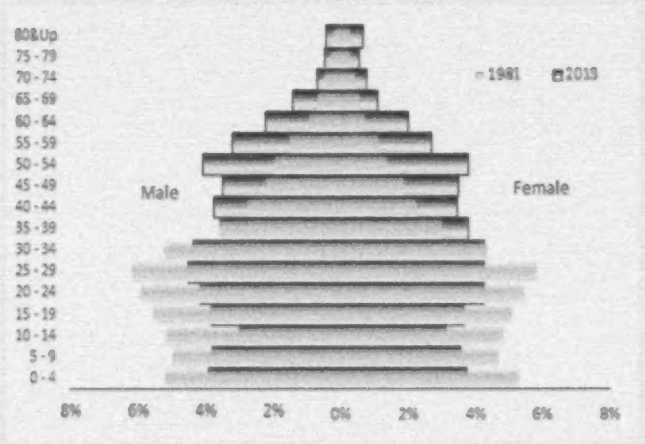
Every region in the NWT will gain a voice in the design and delivery of territorial programs and services, which will be achieved by having the Chairs of Regional Wellness Councils sitting as members of the NWT HSSLC. This structure will respect the rights of Aboriginal self-governments to draw down jurisdiction, and provide a seat at the table for Aboriginal governments, in a way that meets their requirements.

Operating Environment

Where are we now?

Many of the factors driving cost and demand on the NWT Health Social Services System are complex and beyond our ability to influence or control. Drivers include high rates of chronic disease, an aging population, impacts of residential schools, human resource pressures, remote communities, increasing medical travel costs, pharmaceutical costs, and increasing costs for out-of-territory services. These drivers add to the cost of delivering health and social services.

The NWT population is aging, as illustrated by the population pyramid showing change in the age structure of the population over the last three decades.



The population age 60 and over is expected to more than double by 2031, while the population under 60 is projected to decrease. The implications of the growing senior population for the health system will include increased demand for long-term care, home care, pharmaceuticals, and chronic disease related care.

Currently, 43% of the NWT population is moderately active or active. The prevalence of current daily smokers in the NWT is nearly double the Canadian rate (25% vs 14%). One out of every seven NWT residents has high blood pressure while 62% are obese or overweight. Obesity, smoking and physical inactivity are risk factors associated with cancer, circulatory and other chronic diseases.

Several chronic conditions are growing issues in the NWT: diabetes, hypertension, asthma and chronic obstructive pulmonary disease (COPD). These conditions are often preventable and, if not properly treated and managed, can lead to serious complications and, in some cases, premature death. Between 2001 and 2010, the proportion of the population affected by diabetes has increased at an average rate of 5.2% per year, hypertension at 3.3%, asthma at 4.3%, and COPD at 1.5%.

The NWT has a higher rate of potentially avoidable deaths than the national average – 26 versus 18 per 10,000 (population).[1] In the NWT, the leading causes of avoidable deaths were injuries, cancers and cardiovascular diseases. Together these three groups of conditions were responsible for 72% of all potentially avoidable deaths.[2] Achieving success in the areas of injury prevention, early detection and treatment of disease, as well as the promotion of healthy lifestyles would go a long way in reducing avoidable mortality.

Hospitalizations represent some of the severest outcomes of diseases and injury that occur in the population, as well as resulting in the greatest financial burden on the health system. Injuries and cardiovascular diseases are also two of the top five conditions in terms of hospitalizations, along with respiratory diseases, digestive system conditions, and mental health and addiction issues. Many hospitalizations for these conditions are avoidable, and together they represent over two-thirds of all hospitalizations of NWT residents.[3] Over half of the mental health hospitalizations are associated with alcohol and drug use. The NWT has a rate of self-inflicted injury hospitalizations that is three times that of Canada (21 versus 6.7 discharges per 10,000).

Heavy drinking can have serious short-term and long term consequences for the individual drinker and those affected by negative outcomes of drinking. Consequences include chronic health conditions, as well as assaults, family and social violence and dysfunction. Heavy or binge drinking is often defined as having had five or more drinks on occasion at least once per month over a 12 month period. In 2012, 30% of NWT residents surveyed were found to be heavy drinkers, compared to 19% nationally. Perceived mental health refers to the perception of a person's mental health in general. In 2012, the NWT had significantly lower rates of the population, compared to the national average, reporting that their mental health was very good or excellent – 63 versus 72%

Children abused, maltreated, neglected and having grown up in highly dysfunctional homes are at a higher risk to experience issues later in life, including: poor mental and physical health outcomes, addictions, violence (victim and perpetrator). In any given year, approximately 7% to 9% of the NWT population under the age of 19 is receiving services under the Child and Family Services Act (on a voluntary or involuntary basis).

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[1] Rates are standardized to the Canadian population. Rate for NWT is for five years (2007 to 2011) and for Canada three years (2007 to 2009). Avoidable mortality includes deaths under the age of 75 due to causes (diseases/events) that are considered either potentially preventable or potentially treatable. NWT Department of Health and Social Services, Statistics Canada and NWT Bureau of Statistics.

[2] Deaths between 2007 and 2011; Statistics Canada and NWT Department of Health and Social Services.

[3] Based on hospitalizations, between 2008/09 and 2012/13, where the primary reason for the hospitalization is for a known or suspected condition (i.e. not for an ill-defined condition, nor for aftercare, palliative care etc). Canadian Institute for Health Information and NWT Department of Health and Social Services.

Approximately half of the NWT population is Aboriginal and there remains a significant disparity between the health status of the aboriginal population and that of the non-aboriginal. Among Aboriginal people, mental health and addiction issues are often linked to the legacy of colonialism and the multi-generational impacts of residential school experiences. As understanding grows about the need to deal with these issues, the demand for services will increase and change.

In order to improve the health status of the population, the Department will need to effectively plan to meet the needs of our aging population. We need to focus on promotion and prevention; early childhood development; improve the provision of services to children and families; community based wellness initiatives; and implementation of a chronic disease management model that incorporates education, prevention and self-care. We will involve communities and individuals in identifying solutions that are culturally appropriate and integrate their own unique strengths and resources, thus avoiding the pitfalls of "one-size-fits-all" approaches that may not adapt to well to our many diverse communities.

Where are we going?

In addition to moving to an integrated and single system structure, we are also moving to a single system approach for planning. System wide commitment to achieving a shared vision, mission, goals and objectives will improve accountability for system performance and increase efficiencies by maximizing the use of our human resources, facilities and every dollar we spend. This single system approach to planning will strengthen partnerships and coordination across the system; resulting in improved access to care for our residents, improved health outcomes for our patients/clients and a more sustainable health and social services system.

VISION

Best Health, Best Care, for a Better Future.

Through this vision, we will work on simultaneously improving the health of the population, enhancing the experience and outcomes of the patient/client, and ensuring the ongoing sustainability of the system for future generations.

MISSION

Working in partnership to provide the highest quality care and services and encourage our people to make healthy choices to keep individuals, families and communities healthy and strong.

VALUES

Caring - we treat everyone with compassion, respect fairness and dignity and we value diversity

Accountable - system outcomes are measured, assessed and publicly reported

Relationships - we work in collaboration with all of our residents, including; Aboriginal governments, individuals, families and communities

Excellence - we pursue continuous quality improvement through innovation, integration and evidence based practice

GUIDING PRINCIPLES

A system that:

- Is focused on the patient/client
- Supports individuals and families to stay healthy
- Ensures regions have a voice at the territorial level
- Ensures equitable access to care and services

- Emphasizes quality care
- Is sustainable
- Is respectful of diversity and all cultures

GOALS

1. Improved health status of the population through prevention and education
   - Promote healthy choices and personal responsibility through awareness and education
   - Decrease incidence of chronic disease with a focus on diabetes and cancer
   - Reduce incidence of addictions
   - Provide targeted access to services for high-risk populations to reduce disparities in health status and the impacts of social determinants

2. Care and services are responsive to children, individuals, families, and communities
   - Deliver safe quality and appropriate care and services
   - Reduce gaps and barriers to current programs and services
   - Enhance the patient/client experience
   - Ensure programs and services are culturally sensitive and respond to community wellness needs

3. Ongoing sustainability of the health and social services system
   - Improve partnerships and collaboration
   - Enhance the skills, abilities and engagement of the HSS workforce
   - Support innovation in service delivery
   - Improve accountability and manage risk
   - Ensure appropriate and effective use of resources

2. RESOURCE SUMMARY

Departmental Summary

	(thousands of dollars)			
	Proposed 2015-16 Main Estimates	2014-15 Revised Estimates	2014-15 Main Estimates	2013-14 Actuals
Operations Expenses by Activity				
Activity 1 - Directorate	10,311	10,059	10,016	9,731
Activity 2 - Program Delivery Support	50,946	49,277	46,490	44,930
Activity 3 - Health Services Programs	212,682	208,647	209,007	211,240
Activity 4 - Supplementary Health Programs	27,321	27,300	27,300	29,968
Activity 5 - Community Programs	99,437	97,226	99,116	95,108
Total Operations Expenses by Activity	**400,697**	**392,509**	**391,929**	**390,977**
Operations Expenses by Object				
Compensation and benefits	21,810	21,136	21,199	21,491
Grants and Contributions	282,549	275,411	273,995	265,532
Other	85,067	84,691	85,464	95,176
Amortization	11,271	11,271	11,271	8,778
Total Operations Expenses by Object	**400,697**	**392,509**	**391,929**	**390,977**
Revenues	**48,764**	**45,055**	**45,055**	**57,328**

Human Resources Summary

	Proposed 2015-16 Main Estimates	2014-15 Revised Estimates	2014-15 Main Estimates	2013-14 Actuals
Department	179	179	177	173
Health and Social Services Authorities	1,417	1,398	1,392	1,353
Total Number of Positions	**1,596**	**1,577**	**1,569**	**1,526**

Key Activity 1 - Directorate

Description

Under the authority of the Minister, the **Directorate** provides strategic leadership to the Department and the Territorial Authority. This includes responsibility for overall coordination of strategic reform initiatives aimed at ensuring the long-term sustainability of the health and social services system. The Directorate is responsible for broad system planning, establishing strategic direction, providing innovative leadership, coordination and risk management as well as the provision of administrative services for departmental operations.

The **Policy, Legislation and Communications** Division provides leadership and services in the development of policy, legislation and regulations along with Intergovernmental relations, Aboriginal affairs, Official Languages and Communications, as well as coordination of *Access to Information, Protection of Privacy* requests and records management.

The **Corporate Planning, Reporting and Evaluation** Division is responsible for setting a system-wide framework for planning and accountability to ensure that Department priorities respond to system-wide health and social issues and reflect priorities set by government. This Division is also responsible for monitoring program performance and conducting evaluations to support evidence based decision-making. Responsibility for professional licensing is also included in the Division.

The **Finance** Division provides financial planning and management services for the health and social services system. These services include providing guidance and support to the Department and the Authorities on financial monitoring, financial analysis, transaction processing and procurement.

The **Infrastructure Planning** Division is responsible for the overall development, design and planning of capital infrastructure projects. Planning, purchasing and ever-greening for medical equipment is also included in this Division.

The **Shared Services and Innovation** Division provides overall leadership and guidance on the strategic planning and implementation of several key system reform initiatives that collectively will change the structure of health and social services delivery in the NWT. Reform initiatives include a modernization of the Medical Travel policy and program, planning and implementation of non-clinical shared services across the Authorities and the Department, and a Med-Response system and service that will provide both clinical support and coordination of air ambulance services for patients in remote communities.

Improving Management of the Health and Social Services System

A significant amount of work has been undertaken over the last number of years to improve the health and social services system. Extensive engagement with Aboriginal organizations, communities and residents of the NWT informed the development of a new structure that will better meet the needs of our residents.

Work initiated in 2014/15 includes:

- Developing an updated accountability framework that clearly outlines roles and responsibilities for the new NWT HSSLC Chair and Members, the Regional Wellness Councils, the Department and the Territorial Authority and Regional Offices;
- Developing detailed financial analysis of the implications of transition to the new structure, including one-time transitional costs;
- Developing options for bringing employees of the Hay River Health and Social Services Authority into the public services;
- Developing an implementation plan and communications plan; and
- Finalizing draft legislation to amend the Hospital Insurance and Health and Social Services Administration Act.

This will position the Health and Social Services System for transition to the new structure.

Ongoing Sustainability of the System

As part of improving effectiveness and efficiency, and service delivery, the health and social services system has undertaken significant planning to allow us to implement a single Information Systems Service Centre (ISSC). In 2013/14 analysis was done to provide a detailed organizational model and cost to implement information technology and information systems shared services (IS/IT). Part of the plan requires the full migration of all the health and social services system to the Technology Service Centre (TSC) under Public Works and Services.

In 2015/16 the Health and Social Services ISSC organizational structure will be created, additional resources will be required to support enterprise-wide health and social services systems (e.g., Electronic Medical Record). Where it is practical and safe to do so, Health and Social Services IT systems will be transitioned to the TSC for support.

We will continue to increase efficiency and capacity by integrating corporate services among the existing eight authorities. Services, such as finance and accounting functions, purchasing, information systems and recruitment, will be coordinated through the single Territorial Authority.

Improving Accountability and Performance Measurement

Over the last number of years, we have been moving forward on initiatives aimed at improving accountability for the performance of the Health and Social Services System. The last Strategic Plan; *Building on our Foundation 2011 – 2016*, included commitments to enhance the ability to monitor and report on outcomes and included a preliminary set of performance indicators. A report on these indicators was included in the last two Health and Social Services Annual Reports.

In 2013/14 we concluded a review of the current state of accountability and performance measurement of the system, compared it to best practice, identified the gaps, and developed a new performance measurement framework and related accountability framework components. Through this process, we developed an initial list of 32 performance indicators. It is our intention to begin publicly reporting on these performance indicators in early 2015.

Work will be undertaken in 2015/16 to formalize an accountability framework for the new structure, update the contribution agreements, develop a funding methodology, develop a risk-based evaluation plan and publically report progress on the Early Childhood Development, Mental Health and Addiction and Anti-Poverty Action Plans. For the 2015/16 Main Estimates and future Business Plans, we will also modify the financial accounting and reporting structure to provide more detailed information on budget allocations of the Health and Social Services System.

Legislative Framework in Support of the Health and Social Services Mandate

The Department of Health and Social Services is dedicated to the maintenance of a modern legislative framework that supports patient-focused, accountable, sustainable, and effective health and social services delivery, which meet the needs of NWT residents. So far during the 17th Legislative Assembly, the Department has delivered on the following legislative projects:

- Implementation of the *Social Work Profession Act*;
- Development of *Vital Statistics Regulations*, allowing the NWT to bring into force a modern *Vital Statistics Act*;
- Amendments to the *Change of Name Regulations;*
- Amendments to the *Hospital and Health Care Facility Standards Regulations* under the *Hospital Insurance and Health and Social Services Administration Act* (HIHSSA) to allow Registered Nurses with appropriate training to fulfill the legislative requirement of having an Operating Room First Assistant for every surgery carried out;
- Amendments to the *Hospital Insurance Regulations* under HIHSSA to replace out of date fees for Long Term Care beds with a rate system;
- Amendments to the *Dental Profession Act* to modernize the legislative framework and to

enable dental students to practice in the NWT;

- Amendments to the *Medical Care Act* to remove members of the RCMP from the list of residents not eligible for insured services in the NWT;
- Implementation of the *Immunization Regulations* under the *Public Health Act*, which set out a list of notifiable immunizations and require health care professionals to report the administration of these immunizations to the Chief Public Health Officer;
- Implementation of *Personal Service Establishment Regulations* under the *Public Health Act*, which set public health standards and requirements for professionals and establishments such as hairdressers, estheticians, tattooists, acupuncturists, massage therapists, naturopaths, gyms, and sun tanning salons, including the requirement for a personal service establishment permit issued by the Chief Public Health Officer; and
- The passing of the *Health Information Act*.

The Department continues to move forward on a number of other critical legislative projects to support the priorities of the 17th Legislative Assembly.

Health and Social Services Professions Act - A new *Health and Social Services Professions Act* is being developed. Drafting of a Bill has begun and is expected to be ready for introduction in the fall 2014. Work on professional regulations has begun and will continue in 2015/16. The first set of professionals to be regulated under the Act will be:

- Emergency Medical Service Providers;
- Psychologists;
- Licensed Practical Nurses; and
- Naturopathic Doctors.

Child and Family Services Act - Substantive amendments to update the *Child and Family Services Act* are being developed. A Bill should be ready for introduction in May/June 2015. The amendments to the Act will address many recommendations made in response to the recent review of Child and Family Services undertaken by the Office of the Auditor General.

Mental Health Act - The Department is developing a new *Mental Health Act* (MHA). This new Act will modernize current legislation and put into place comprehensive measures for protection of rights for persons with mental illness. During 2015/16 the Department hopes to continue the development of a Bill and is aiming for introduction of the Bill before the end of the 17th Legislative Assembly.

Hospital Insurance and Health and Social Services Administration Act - The Department is moving forward with the drafting of a Bill to amend the Act, to resolve long standing issues respecting authority, accountability and quality assurance. The amendments support a seamless approach to the delivery of care and services to all NWT residents. A Bill amending the Act

should be ready for introduction early in 2015 with implementation efforts ramping up during 2015/16 and into the following fiscal year.

Human Tissue Donation Act - A Bill replacing the Act with a new *Human Tissue Donation Act* was introduced in June 2014. The new Act will provide a more comprehensive legislative framework for consenting to donate organs and tissues in the NWT. The new Act will also fill the gaps of the current Act by addressing consent, live donor transplants, and the prohibition of the sale of body parts or benefitting from donation. The new legislation will allow the NWT to provide a functional donor registry for NWT residents.

Pharmacy Act - A Bill amending the *Pharmacy Act* was introduced in June 2014. The Bill amends the Act to ensure that provisions related to the establishment, administration and operation of a prescription monitoring program apply notwithstanding the *Access to Information and Protection of Privacy Act* that would otherwise restrict the Department's ability to establish such a monitoring program. Regulations under the *Pharmacy Act* establishing the monitoring program are also required. The Department aims to roll out the prescription monitoring program in 2015/16.

Ground Ambulance Act - As part of the Government of the Northwest Territories' strategy to address gaps in ground ambulance, highway rescue, and remote rescue services, the Department of Health and Social Services is developing legislation to set out health-related standards for ground ambulance services. If the initiative is supported, the Department hopes to have a Bill ready for introduction in spring 2015.

Insured Services Legislation - The Department is reviewing the NWT insured health services legislative framework, currently set out in the *Medical Care Act* (MCA) and *Hospital Insurance and Health and Social Services Administration Act (HIHSSA)*. During 2015/16 the Department will move forward with a proposed renewal of this legislative framework to improve transparency, reduce administrative burdens, and better meet the needs of NWT residents. As part of this work, the Department will be recommending standalone legislation on insured services, thereby removing the insured services piece within HIHSSA and replacing the MCA.

Implementation of the Health Information Act - The Health Information Act (HIA) Bill was passed in March 2014. There is a significant amount of work necessary to bring the HIA into force. The Department has begun implementation and aims to have the Act brought into force in 2015/16. A Health Privacy Unit is being established within the Policy, Legislation and Communications Division of the Department of Health and Social Services. The Unit will provide ongoing dedicated health privacy support and expertise to the Department, the Territorial Authority, private pharmacists and private physicians, and includes four staff: two new positions (2014/15) and two existing positions.

Start-up activities that will be carried out by the Unit include: drafting regulations to have the Act come into force; developing an HIA training manual and online training workshops; delivering training; developing health privacy and security policies, including privacy breach protocols; developing and delivering an HIA public awareness campaign; establishing an NWT Research

Ethics Committee; and applying for 'substantial similarity status' under the federal *Personal Information Protection and Electronic Documents Act* (PIPEDA), allowing private pharmacists and physicians to only be required to follow the NWT HIA requirements and not PIPEDA as well.

The ongoing functions that will be carried out by the Unit include; administration and enforcement of the HIA; responding to HIA and ATIPP reviews by the Information and Privacy Commissioner; establishing and participating in a health information governance committee; and providing strategic privacy and security advice to the Department, Territorial Authority, private physicians and pharmacists.

French Language Services Action Plan

In 2015/16, we will use an existing $1.1 million, including approximately $300,000 in federal funding, to continue the implementation of an operational plan for French Language Communications and Services. This funding provides for five (5) full-time French Language System Navigator positions for Fort Smith, Hay River, Beaufort Delta, Yellowknife, and Stanton. The funding also provides for one (1) full-time certified bilingual Medical Interpreter at Stanton and one (1) bilingual Health Care Eligibility Coordinator position within the Department's Health Services Administration Office, located in Inuvik. We will work in collaboration with the Francophone Affairs Secretariat and the Francophone Community in developing tools to monitor and evaluate the provision of French Language Communications and Services.

Cross-Departmental Initiatives

Ground Ambulance and Highway Rescue

The Department of Health and Social Services is a project partner, working with the Departments of Justice (DOJ), Transportation (DOT), and Municipal and Community Affairs (MACA) to develop protocols for remote medical evacuation.

We are also working with our project partners to ensure the training and availability of first responders.

The Department is consulting key stakeholders, including communities, ground ambulance service providers, air ambulance and other industry providers, on options for standards legislation.

French Language Services Action Plan

In collaboration with the Francophone Affairs Secretariat of the Department of Education, Culture and Employment (ECE) and the Francophone Community, we developed a multi-year operational plan to enable the implementation of the Strategic Plan on French Language Communications and Services and its court mandated legal obligations for the provision of French Language Services.

Performance Measures

As part of our commitment to accountability and performance monitoring, the following performance measures are being developed for Key Activity 1. Public reporting on these indicators will begin in early 2015.

- Variance - The variation between total projected expense and total actual expense for Health and Social Services
- Compliance with reporting requirements
- Staff Safety - The proportion of all documented critical incidents that impacted the safety of health and social services staff members

Key Activity 2 - Program Delivery Support

Description

The Department provides ongoing system wide program planning, standards development and advice in the delivery of health and social programs.

The **System Human Resources Planning** Division is responsible for coordinating system-wide planning and promotion of health and social services careers. This includes working in collaboration with the Department of Human Resources to forecast health and social services human resources needs, and the design, delivery and evaluation of programs to support recruitment and retention specifically related to health and social services professionals.

The **Information Services** Division leads informatics initiatives in support of the broader systemic goals of Health and Social Services. The Division provides operational support to departmental and territorial systems, and provides planning, implementation and investment support for new territorial health and social services initiatives, and data standards.

The **Health Services Administration** Division is responsible for the administration of the Health Benefits programs (including Insured Health Benefits, Extended Health Benefits, Catastrophic Health Benefits, Métis, Non-Insured Health Benefits and inter-jurisdictional billings for Hospital and Physician Services). The Division is also responsible for providing leadership and direction to the Authorities in the administration of Insured services, reciprocal billing and Health Benefits eligibility and registration. The Vital Statistics, Registrar General is also located in this Division providing the registration and issuing of certificates for vital events that occur in the NWT.

The **Territorial Health Services** Division ensures standards and policies are in place to guide the delivery of health services throughout the NWT. Specifically, this Division is responsible for the planning, development, coordination, monitoring and review of: acute care; long-term care; homecare; seniors and persons with disabilities; rehabilitation; maternal and child health and oral health; community health programs and physician services.

The **Office of the Chief Public Health Officer** is responsible for establishing a system response to broad population health issues. This Office guides wellness surveillance activities and coordinates responses in the areas of health promotion, environmental health disease control and epidemiology. The system's response to population health issues such as cancer, early childhood development, anti-poverty and environmental contaminants are coordinated out of this office. The mandate and responsibilities of the Chief Public Health Office are largely defined from the *NWT Public Health Act*.

The **Population Health** Division is responsible for services aimed at broad population health through co-ordination and ongoing management of health and wellness surveillance activities for the NWT. This includes the development of program standards, monitoring and evaluation in the areas of public health, environmental health, disease control and epidemiology.

The **Aboriginal Health and Community Wellness Division** works directly with community groups and Aboriginal governments to identify key community specific priorities and help in the development of appropriate responses. The Division also provides communities with injury prevention and health promotion expertise to support community wellness plans, assists with the integration of traditional healing into primary care and explores best practices for culturally appropriate service delivery.

Health and Social Services Authorities Administration includes funding to Health and Social Services Authorities/Authority for activities associated with management and administration.

Responding to Priorities

Early Childhood Development

"Ensure a fair and sustainable health care system by investing in early childhood" – 17th Legislative Assembly Caucus Priorities

The GNWT tabled *Right from the Start: A 10 year Framework for Early Childhood Development in the NWT* along with a two year Action Plan. This work is the result of extensive public engagement. Engagement tables were convened in every region of the NWT and elders from each community were invited to share traditional knowledge about early childhood development and learning.

As committed to in these documents, we will increase access to evidence based services that support improved outcomes for mom and baby; and expand early intervention programming. We will also improve early childhood assessments, interventions and responses; improve coordination and integration of ECD programs and services; and increase the availability of promotion, awareness and education initiatives related to early childhood development.

Anti-Poverty Framework

"Healthy, educated people free from poverty" – 17th Legislative Assembly Caucus Priorities

Through partnerships with Aboriginal governments, the No Place for Poverty Coalition, community governments and business, the GNWT tabled *Building on the Strengths of Northerners: A Strategic Framework Toward the Elimination of Poverty in the NWT,* and the GNWT Action Plan.

Through the implementation of the GNWT Action Plan we will support vulnerable children and families; we will focus on initiatives aimed at healthy living and helping our residents to achieve their potential; safe and affordable housing; sustainable communities; and providing an integrated continuum of services.

In 2014/15, $500,000 was allocated in the budget to support the Anti-Poverty Funding Program. This funding program is available to non-government organizations (NGOs), Aboriginal organizations, and community based organizations to advance specific priorities of the Anti-Poverty Strategic Framework. The Anti-Poverty Funding Program will be available on an annual basis.

Departmental Highlights

Improving access to services

Midwifery – The establishment of a Midwifery Program is part of a system-wide approach to respond to needs for quality pre and post natal care, education, and in-community birthing for low-risk deliveries. Based on a 2012 review and analysis of midwifery services, decisions were made to expand the Midwifery Program to Hay River, and to consult with Beaufort Delta residents and authority staff, regarding the region's needs for pre and post natal care. Consultation with program and medical staff in Hay River was complete in 2013 and the new Hay River Health Center, scheduled to open in 2015/16 will accommodate birthing services. Consultation in the Beaufort Delta region will be completed in 2014/15.

Chronic Disease Prevention and Management - Renal, mental health and diabetes projects were piloted to improve chronic disease management in the territory. A final evaluation report, entitled *Making the Case for Change*, was released in September 2013. The knowledge gained from these projects is being used to improve chronic disease care in the NWT, and will be incorporated into broader chronic disease prevention and management strategies.

We are delivering two projects in the area of chronic disease prevention. The NWT BETTER project promotes the empowerment of individuals, families, and communities to make informed choices about chronic disease screening, prevention, and the adoption of healthy lifestyle behaviors. The Working on Wellness program in the NWT works with employers in private and public sectors. These projects are receiving 3rd party funding by the Canadian Partnership Against Cancer through the Coalitions Linking Action and Science for Prevention Initiative.

Supporting individuals living with cancer - We released the NWT Cancer Report 2000-2010 that describes the incidence of various cancer types. This report also compares NWT rates to national

rates and breaks down cancer rates by ethnicity. In response to the Cancer Report, we are developing a GNWT Cancer Strategy to guide prevention and support services.

In 2013, we piloted medical terminology development workshops to assist in developing new information material around cancer, and to assist a broad range of health workers to communicate more effectively with patients dealing with cancer and other health issues. Workshops were piloted in Fort Good Hope in North Slavey; Hay River Reserve in Chipewyan and South Slavey; and Inuvik in Gwich'in. We will continue to hold medical terminology workshops during 2015/16.

We have also held three Cancer Sharing Circles in Fort Good Hope, Fort Resolution and Fort Liard. These workshops allow community members and health professionals to come together and share how cancer has impacted their lives and what steps we might take to address disparities and gaps. We will continue to hold Cancer Sharing Circles during 2015/16.

We have secured funding from Canadian Partnership Against Cancer to implement two projects focusing on improving continuity of care and relationships with care providers for Aboriginal cancer patients. These two projects will continue in 15/16.

Clinical Governance

The Department continues to review, revise and roll out clinical practice guidelines to standardize the quality of care available to all residents of the NWT. Under the leadership of the Chief Clinical Advisor, the Department is developing an ethical decision making framework. This will provide a step-by-step, fair and transparent process to help guide health care providers and administrators working through complex ethical issues encountered in the delivery of health care. We will undertake the development of the ethical decision making framework in 2014/15 and begin implementation in 2015/16.

To enhance cultural capacity and improve patient outcomes, the Department will develop a cultural competency training module in 2014/15. We will begin delivery of this training to healthcare providers in 2015/16.

Med-Response is a new service that will provide Air Ambulance triage and coordination along with 24/7 access to a physician, to support healthcare practitioners across the territory. Med-Response is expected to be implemented in the fall of 2014. The Department is working with an external team funded by the Canadian Institute for Health Research (CIHR) on an evaluation framework, to evaluate the success of Med-Response and to ensure ongoing quality improvement.

Promotion and Prevention

- The Department received 3 year funding from Health Canada, starting in 2014/15, to support communities to develop and deliver their own on-the-land programs and tobacco-free living programs.

- The Department continues to develop and deliver positive and empowering messaging about healthy choices and tobacco-free living among youth, and to provide services and support to help people quit. The Department, in collaboration with the Healthy Choices Framework, continues to focus on several tobacco reduction initiatives, particularly the NWT Quitline, My Voice, My Choice, and National Non-Smoking Week.

- Over the last 4 years, more than 30 healthy eating initiatives have been undertaken, ranging from upstream to clinical practice: such as reducing the consumption of sugar sweetened beverages, on-the-land food programs, developing food guidelines and standards, and cooking and training programs in communities.

- Over 200 workshops and training sessions on a range of nutrition topics have been provided to communities throughout the NWT in partnership with Aboriginal governments, NGOs, communities and many others.

- Over the next year, we will support the priorities of the Healthy Choices Framework, and the Early Childhood Development and Anti-Poverty action plans by developing programs and services that encourage healthy eating.

Our Elders: Our Communities

We recently completed a review of continuing care services in the NWT to identify needs and gaps in our current continuum of programming, confirm demographic projections, and explore best practices. *Our Elders, Our Communities* outlines priority areas that we will use to guide future program design and priority setting. Priority areas include:

- Healthy and Active Aging;
- Home and Community Care Services;
- Integrated and Coordinated Services Across the Continuum;
- Caregiver Supports;
- Elder Responsive Communities;
- Accessible and Current Information; and,
- Sustainable Best Practices.

Brushing up on Oral Health: Northwest Territories 2014

On March 31, 2014 we received Northwest Dental Consultant's report, *Brushing Up on Oral*

Health NWT (2014), which provides recommendations for improving oral health in the NWT. This report highlights actions like exploring fluoridation, preventative treatment therapies, investigating the use of oral health teams, oral health education, and the creation of an "oral health" funding envelope.

Over the coming fiscal year, we will review the recommendations in the report for inclusion in an oral health strategy. The NWT oral health strategy will establish priorities to improve access to dental services and oral health promotion and prevention with an emphasis on children and youth.

Health Human Resources

The Department of Health and Social Services engages in various activities to recruit and retain employees in the health and social services system. Much work has been done on developing a new human resources strategic plan that targets areas of greatest need within existing funding. New programs are being developed based on analysis of employment needs across the health and social services system, research on national innovative and best practices to recruit and retain health and social services professionals, findings of current recruitment and retention programs, and consultation with Authority staff and other stakeholders. New programs will begin in 2015.

Supporting innovation in service delivery and patient/client care

Over the past four years, the health and social services system has made a number of strategic investments that have enabled the transformation of service delivery and improved patient care.

- The Interoperable Electronic Health Record iEHR is now available in all NWT communities and has approximately 320 users accessing clinical information on a regular basis.
- Diagnostic Imaging/Picture Archiving Communication System (DI/PACS) are available everywhere that digital imaging services are offered. Radiologists in Yellowknife and in other provinces can review results in as fast as 35 minutes.
- Lab Information System (LIS) and TeleSpeech projects are completed and these systems are now an important component of the NWT health and social services system.
- The implementation of a territory-wide EMR system is underway. In 2014-15, the Yellowknife Health and Social Services Authority (YHSSA) and the Hay River Health and Social Services Authority (HRHSSA) migrated to the Territorial EMR resulting in improved patient outcomes. The Territorial EMR will be implemented in three additional authorities 2014/15 (Stanton, Fort Smith and Sahtu). In 2015/16, pending sustainability resourcing and site readiness, the EMR will be implemented in the remaining three regions.
- Replacement of the Child and Family Services Information System (CFIS) was approved to begin in 2014/15. The investment will replace outdated technology no longer supported

and add functionality to better support delivery of child and family services. In 2015/16, CFIS Replacement activities will continue as year 2 of the 3 year capital project.

In 2014/15, we are developing a Territorial Informatics Strategy and Roadmap to guide informatics strategic investments and priorities. The Strategy will be in place for the start of 2015/16 and, resource dependent, priorities will be advanced in 2015/16.

Cross-Departmental Initiatives

Early Childhood Development Framework and Action Plan

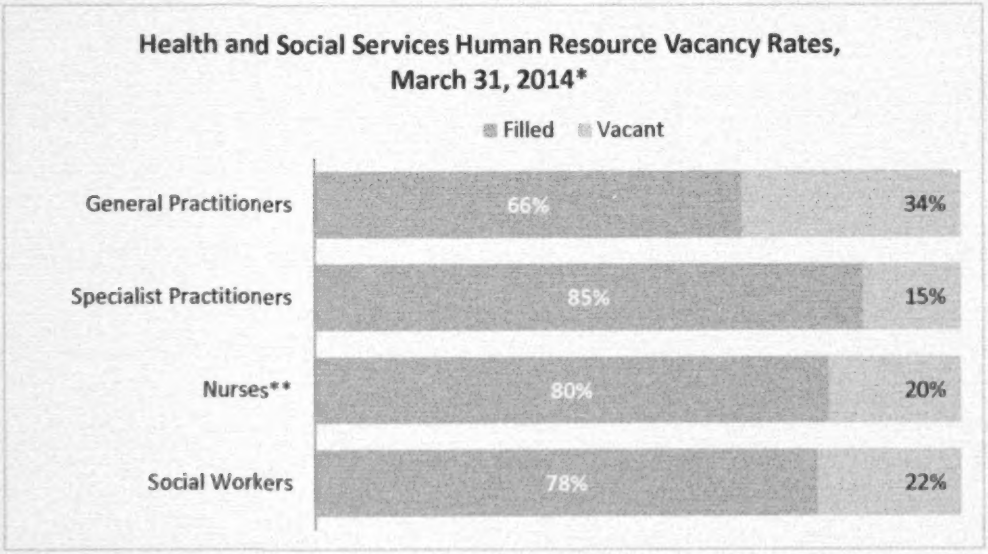
The *Right from the Start Early Childhood Development Framework* (2013) is a joint undertaking between the Departments of Health and Social Services and ECE. The 2015/2016 fiscal year will be year-two in the implementation of the ECD Action Plan. Outcomes include ensuring that every child, family, and community in the NWT, particularly those most at risk, has access to high quality, comprehensive, integrated early childhood development programs and services. These are to be community driven, sustainable and culturally relevant.

Anti-Poverty Framework

Building on the Strengths of Northerners: A Strategic Framework toward the Elimination of Poverty identifies five priorities aimed at tackling the root causes of poverty in the territory. Initiatives will benefit many segments of the population at large, but a key focus is on increasing success rates for Aboriginal children and families by addressing the basic social determinants of health in the NWT's small, remote communities.

Under the lead of Health and Social Services, participating departments include: NWT Housing Corporation; ECE; MACA; DOJ; and Industry Tourism and Investment (ITI).

Figure 1 – Vacancy Rates



* Includes those positions filled by casual or contracted workers (e.g. physician locums).

** Excludes relief nursing positions.

Sources: NWT Department of Human Resources and NWT Department of Health and Social Services.

What is being measured?

The vacancy rate for general physicians, specialist physicians, nurses and social workers

Why is this of interest?

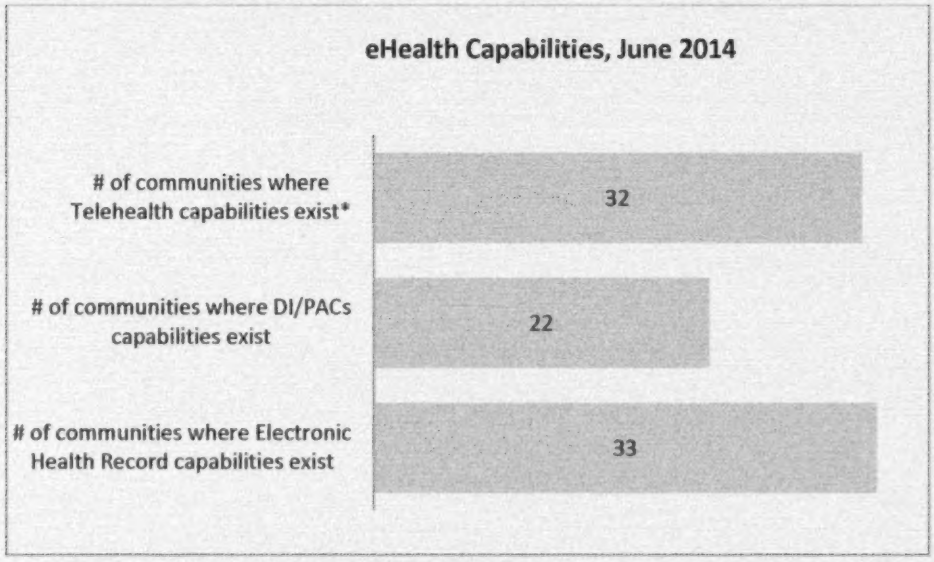
The national shortage of health care workers has shifted the nature of work agreements, resulting in an increased reliance on short-term locum health care professionals. This reliance on a temporary workforce creates significant challenges in delivery of consistent quality care and contributes to higher costs.

Monitoring and analysis of health human resource statistics allows for the development of informed human resource planning, recruitment, education and training initiatives.

How are we doing?

As of March 31, 2014, the general practitioner vacancy rate was 34%, specialist practitioner vacancy rate was 15%, nurse vacancy rate was 20%, and the social worker vacancy rate was 22%.

Figure 2 – eHealth Capabilities


eHealth Capabilities, June 2014
# of communities where Telehealth capabilities exist*
32
# of communities where DI/PACs capabilities exist
22
# of communities where Electronic Health Record capabilities exist
33

* Enterprise is the one community without Telehealth capability.
Source: NWT Department of Health and Social Services.

What is being measured?

The number of communities with access to eHealth technology is being measured

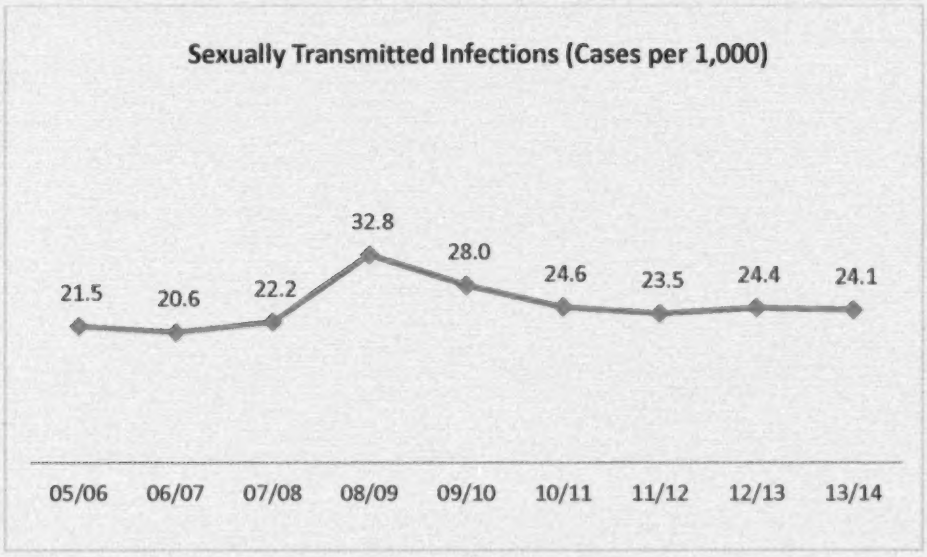
Why is this of interest?

Utilization of eHealth technology will improve patient access in communities and improve patient care and safety and increase efficiencies.

How are we doing?

All NWT communities have the capability of accessing electronic health records. All but one community have Telehealth capabilities. Diagnostic Imaging Picture Archiving and Communication System (DI/PACs) capability exists in all 22 communities, where Diagnostic Imaging services are provided.

Figure 3 – STI Incidence Rates



Source: NWT Department of Health and Social Services.

What is being measured?

The incidence of sexually transmitted infections in the NWT

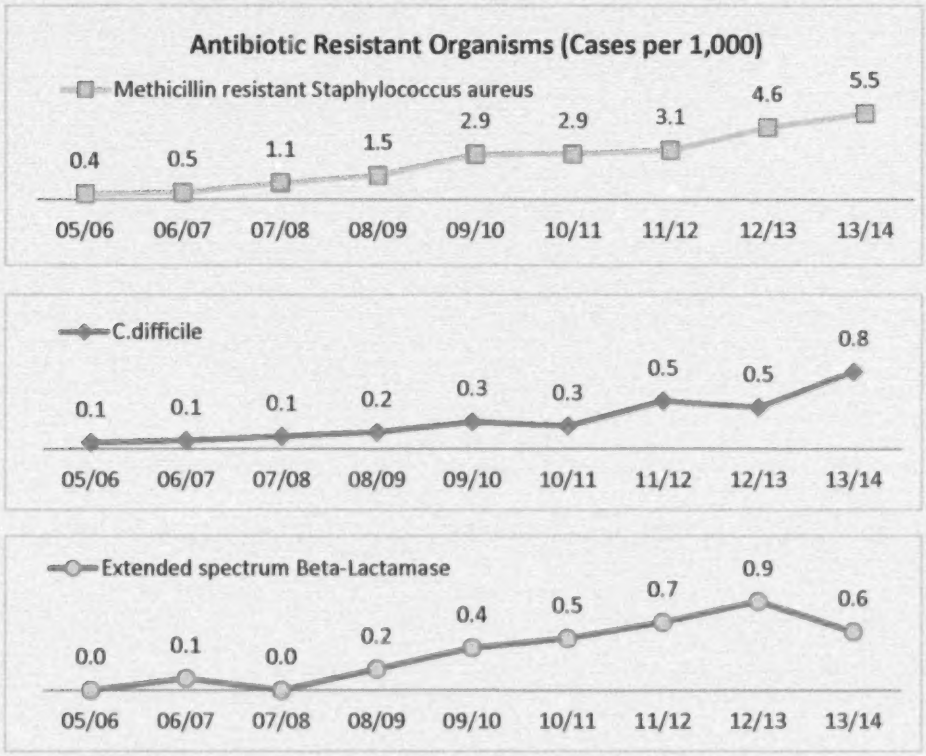
Why is this of interest?

STI rates can provide a proxy of the degree to which unsafe sex is being practiced. Unsafe sex can also spread other more serious infections such as syphilis and HIV. Tracking STIs can also be used as a measure of the effectiveness of promotion and prevention programs.

How are we doing?

While the incidence of STIs has risen over the last eight years and remains one of the highest in Canada, the rate has appeared to have leveled off in the last four years – averaging around 24 cases per 1,000 populations.

Figure 4 – Antibiotic Resistant Organisms - Incidence Rates



Source: NWT Department of Health and Social Services.

What is being measured?

The incidence of antibiotic resistant organism (ARO) infections in the NWT

Why is this of interest?

ARO infections are resistant to many antibiotics and pose a significant danger to the infected person. Methicillin Resistant Staphylococcus Aureus (MRSA) is the most common ARO in the NWT, and has been on the rise in recent years, along with *C. difficile* and Extended Spectrum Beta-Lactamase (ESBL).

While MRSA infections are found in health care settings, in-depth analysis found that most NWT cases tend to arise in community-based settings. *Clostridium difficile* (*C. difficile*) is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. *C. difficile* is generally found to affect older people in hospitals and long-term care facilities. Extended spectrum Beta-Lactamase (ESBL) infections are bacterial infections that are resistant to antibiotics such as penicillins and cephalosporins, generally arising in health care settings but also occurring in community based settings.

By monitoring the incidence of ARO infections, we can assess the effectiveness of promotion and protection campaigns.

How are we doing?

Infections from AROs are on the rise in the NWT. In last five years, the incidence of MRSA has increased by 17% per year, from 2.9 cases per 1,000 in 2009/10 to 5.5 cases per 1,000 in 2013/14. Over the same five years, *C.difficile* has grown by 30% per year, from 0.3 to 0.8 cases per 1,000, and ESBL by 8% per year from 0.4 to 0.6 cases per 1,000.

Improving Accountability and Performance Monitoring

As part of our commitment to accountability and performance monitoring, the following performance measures are being developed for Key Activity 2. Public reporting on these indicators will begin in early 2015.

- Surgical Wait Times - The average time a client waits for NWT based surgeries from the date the surgery booked to the actual date of the surgery.
- Long-term Care Wait Times - The average time a patient waits to receive an offer of placement in a long term care facility.
- Clinical Standards - The rate at which newly established standards of care are adopted by the system as a whole.
- Patient Safety - The average number of critical incidents reported annually.
- Cancer Incidence - The incidence rate of cancers by specified type.
- Diabetes Incidence - The incidence rate of diabetes in the NWT.
- Health Status - Self-reported health status of NWT residents.
- Specialist Wait (referral) Times - The average length of time between the date a specialist referral is initiated and the date of the special appointment.
- School Readiness - The proportion of children entering the K-12 school system with an identified developmental disability.
- Smoking - The percentage of NWT population who self-report smoking.
- Obesity - The percentage of NWT population who self-report obesity.

KEY ACTIVITY 3 - HEALTH SERVICES PROGRAMS

Description

Health services to eligible northern residents in areas such as inpatient and outpatient services, public health and chronic care are provided through the Department and Authorities. Pursuant to the *Hospital Insurance and Health and Social Services Administration Act*, Health and Social Services Authorities are established to operate, manage and control facilities, programs and services.

Hospital Services

- funding to Authorities to provide primary, secondary and emergency care in NWT hospitals
- funding for insured hospital services to NWT residents outside the NWT

NWT Health Centres

- funding to Authorities to provide residents with primary care or "first contact" care through a system of health centres located throughout the NWT

Physician Services

- funding to Authorities to provide insured physician services inside the NWT
- funding for insured physician services to NWT residents outside the NWT

Equipment Evergreening

- funding for medical equipment and vehicles under $50,000

Departmental Highlights

Under the new integrated service delivery model, the Department will work with the Territorial Authority and the NWT HSS Leadership Council to provide NWT residents with access to a comprehensive and integrated health system that provides quality care focused on patient safety.

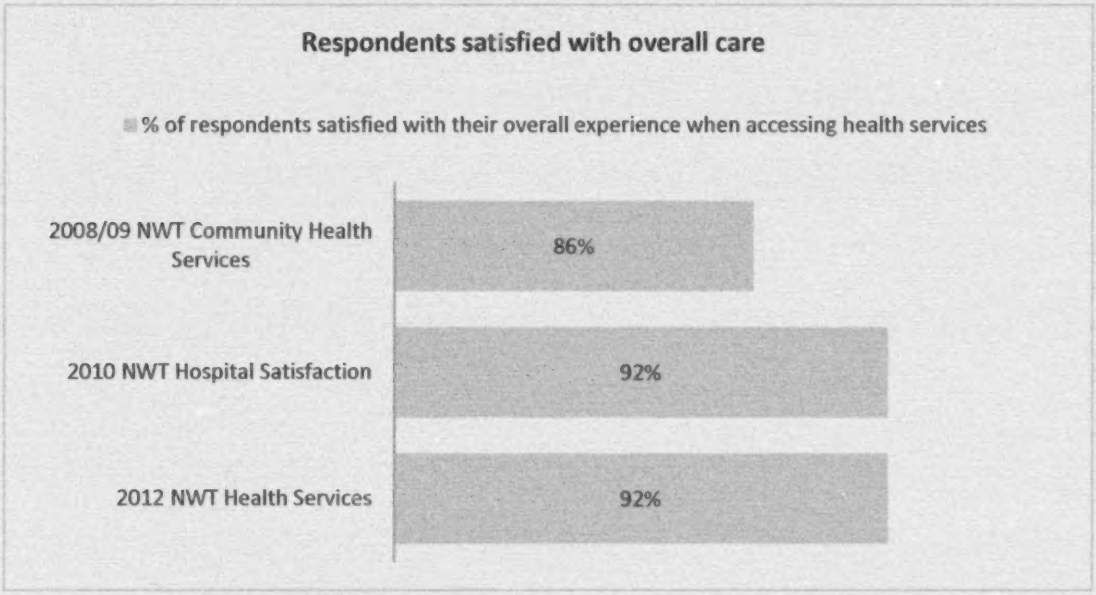
The Department and the Territorial Authority will continue to find innovative solutions to deliver quality care such as Telehealth, Lab Information System, Electronic Health Records, and DI/PACS, to increase efficiencies and maximize existing resources in the delivery of safe patient care.

Through ongoing quality improvement and measurement against national benchmarks and standards, we will continue to improve patient care and safety. Ongoing review of referral processes for access to specialist services, treatment in out of territory facilities as well as

medical evacuations will continue to improve the efficiencies in the system as well as ensuring patients are seen by the most appropriate care provider, resulting in the best patient outcomes.

Performance Measures

Figure 5 – Respondents satisfied with overall care


Respondents satisfied with overall care
% of respondents satisfied with their overall experience when accessing health services
2008/09 NWT Community Health Services
86%
2010 NWT Hospital Satisfaction
92%
2012 NWT Health Services
92%

Source: NWT Department of Health and Social Services.

What is being measured?

The percentage of client satisfaction questionnaire respondents who rated their overall experience when accessing health care services as either excellent or good

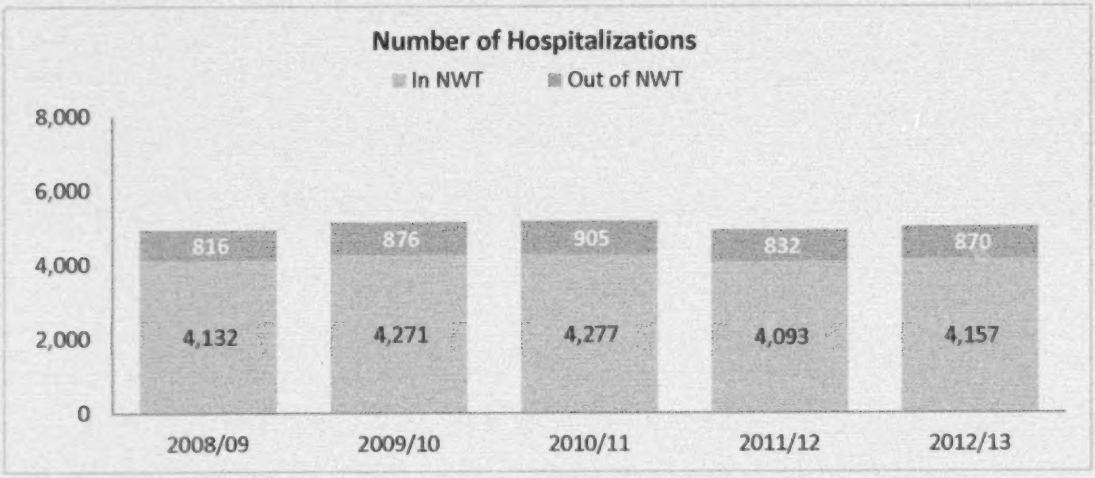
Why is this of interest?

Client satisfaction is a way of gauging the effectiveness of existing services and guiding future developments. Client satisfaction surveys provide NWT residents an opportunity to offer their input and identify where barriers to health care access may exist.

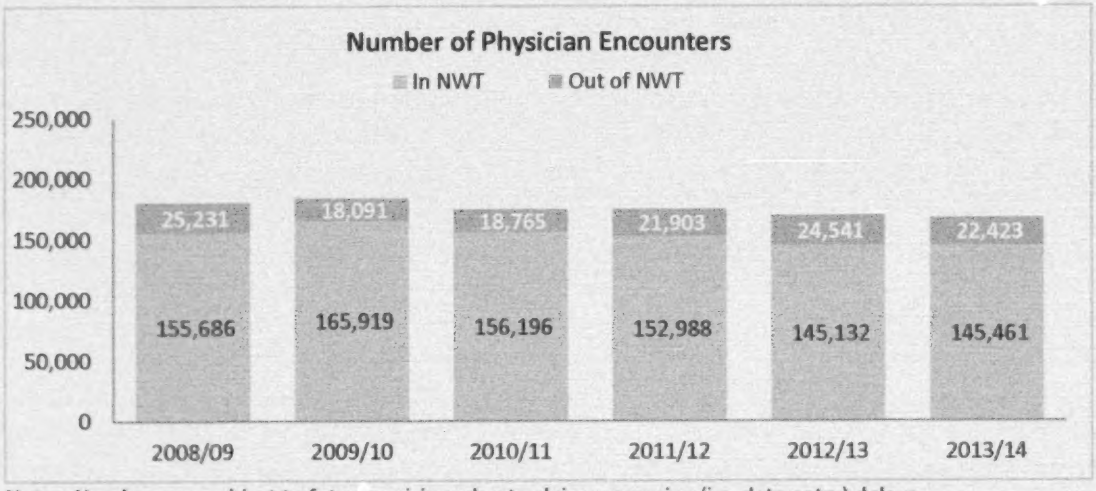
How are we doing?

In the *2012,* 92% of respondents stated that they were satisfied with their overall experience when accessing health services.

Figure 6 – Hospitalizations and Physician Encounters



Sources: NWT Department Health and Social Services and Canadian Institute for Health Information.



Notes: Numbers are subject to future revisions due to claim processing (i.e. data entry) delays.
Source: NWT Department Health and Social Services.

What is being measured?

The number of NWT residents discharged from a hospital and the number of encounters NWT residents had with a physician.

Why is this of interest?

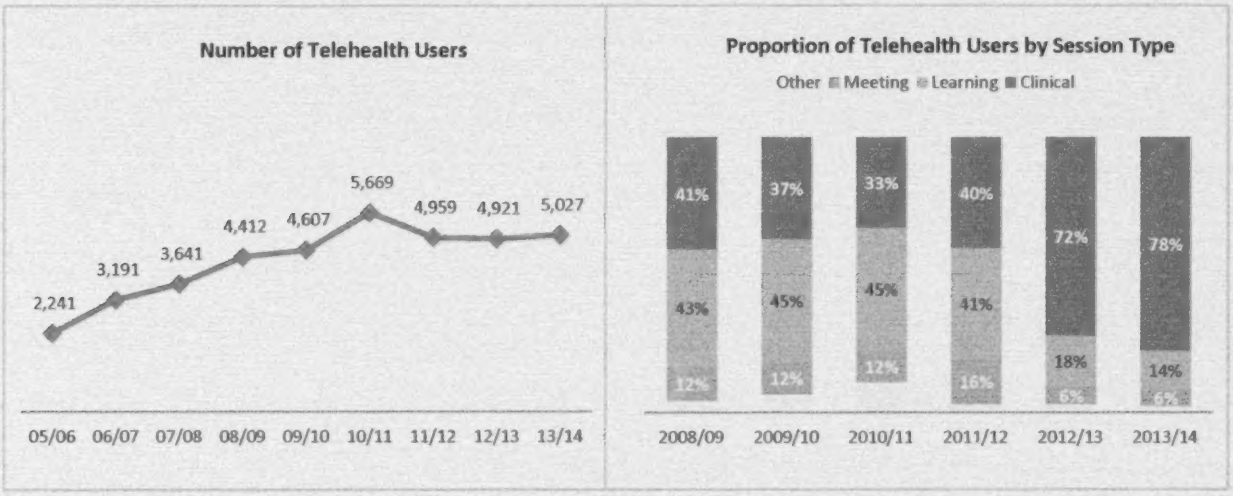
Hospital and physician services are two significant cost drivers in health care expenditures. They represent a significant proportion of the fiscal capacity to serve the population of the NWT. It is important to acknowledge that many hospitalizations are to a great extent preventable by making healthy choices and/or getting help before the condition requires hospitalization.

How are we doing?

The number of hospitalizations has remained steady over the last five years of available data with the number of hospitalizations at NWT facilities averaging around 4,200 per year, and the number at out of NWT facilities ranging between 800 and 900 per year.

The number of physician encounters in the NWT has shown some decline in the last two or three years. However, this apparent decline may be due to claim data processing delays. Out of NWT physician encounters have fluctuated over the six-year period displayed above.

Figure 7 – Telehealth Utilization



Source: NWT Department of Health and Social Services.

What is being measured?

The overall number of telehealth users and the percentage of telehealth users by session type

Why is this of interest?

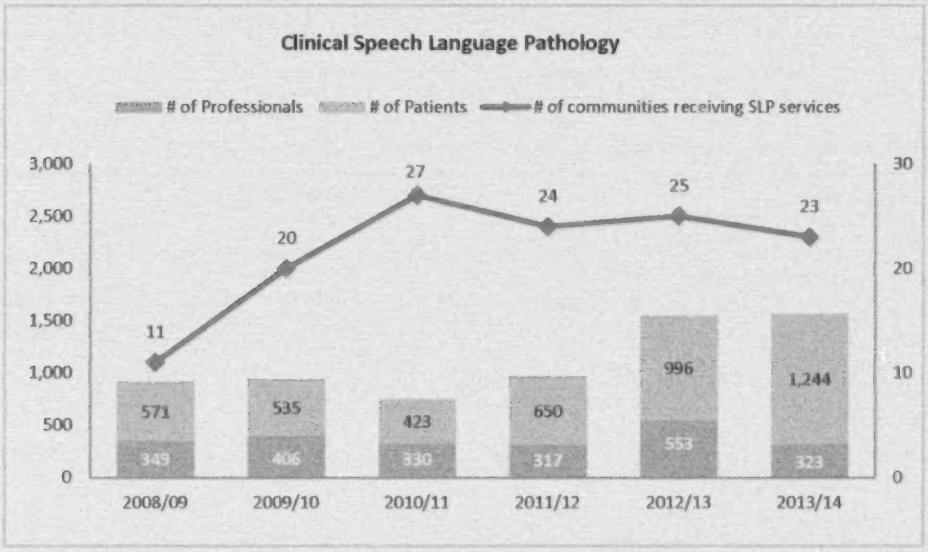
Telehealth can increase access to care, particularly for those patients in remote areas or who would have difficulty accessing the health care system. Telehealth can also help reduce medical and staff travel by providing remote access to clinical advice for patients and professionals as well as education sessions and meetings for health and social services professionals. Telehealth increases the knowledge base of health care professionals and encourages wider and more immediate participation in case management.

How are we doing?

The number of patients and professionals using telehealth has increased over the last nine years, peaking in 2010/11 with 5,669 users. In the last two years the proportion of users using

telehealth for learning has decreased from over 40% in the years prior to 2012/13 to between 14 and 18%. In contrast, the proportion of telehealth users using the system for clinical purposes has increased from just fewer than 40% prior to 2012/13, to between 72 and 78% in the last two years.

Figure 8 – Speech Language Pathology



Source: NWT Department of Health and Social Services.

What is being measured?

The number of clinical speech language pathology (SLP) users and the number of communities using SLP services via telehealth.

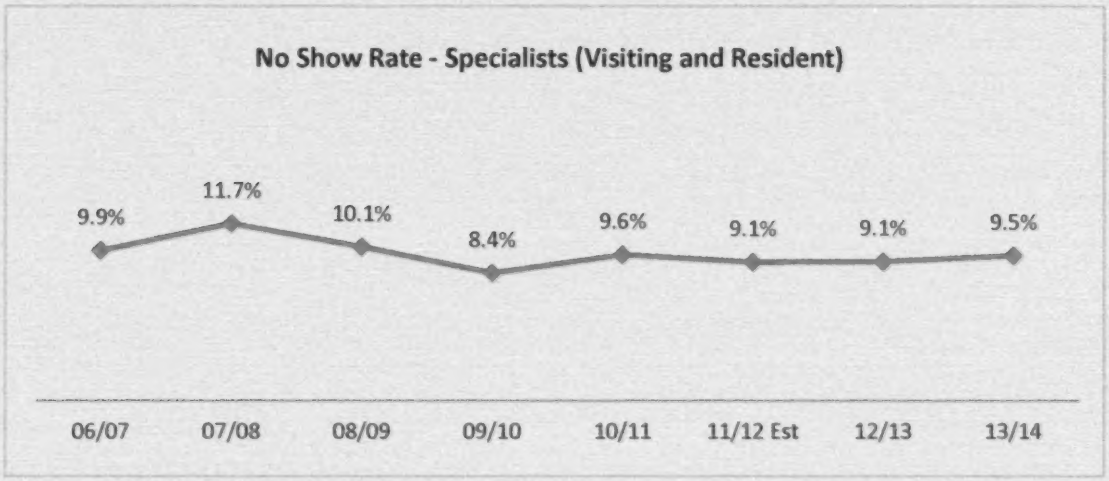
Why is this of interest?

Videoconferencing units ensure that residents, mainly children, are able to access the speech language services they require in their home communities. This is another example of how technology is being used to deliver services in our communities while reducing the demand for medical travel.

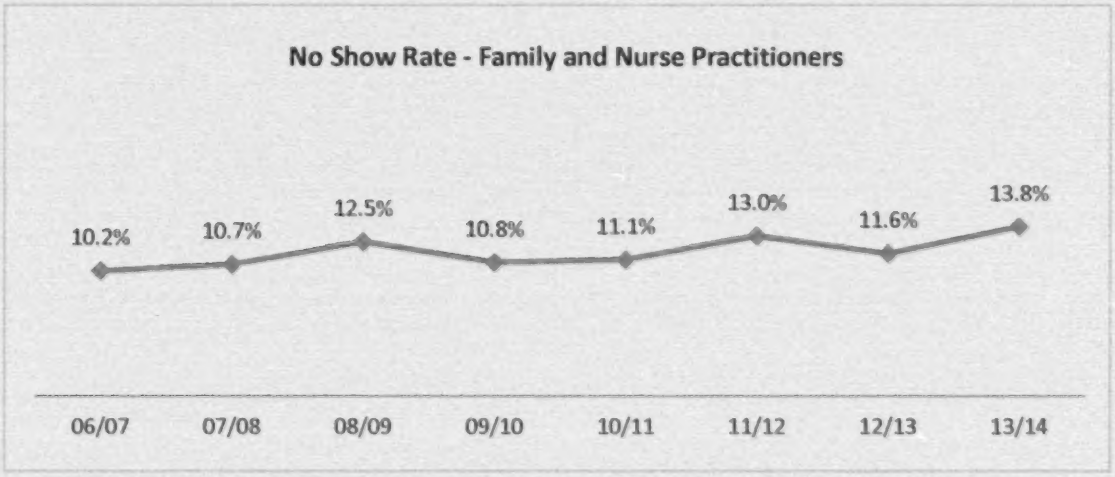
How are we doing?

The number of patients receiving SLP services through telehealth has more than doubled since 2008/09. There were 1,244 SLP patients from 23 NWT communities served through telehealth in 2013/14. The number of communities accessing SLP services has risen since 2008/09, peaking at 27 in 2010/11.

Figure 9 – No Show Rates



Source: Stanton Territorial Health Authority.



Source: Yellowknife and Sahtu Health and Social Services Authorities.

What is being measured?

Scheduled patient appointments with a specialist, family physician or nurse practitioner, where the patient does not show up.

Why is this of interest?

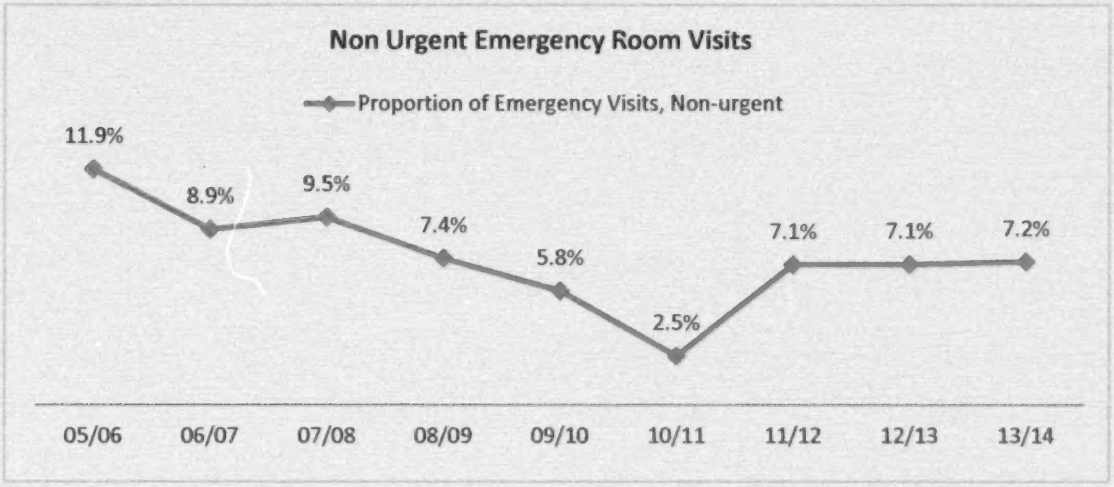
Managing "no shows" contributes to the sustainability of the health care system and ensures our resources are being used effectively and efficiently.

How are we doing?

The no show rate for specialist (excluding travel clinics and ophthalmology) has decreased

marginally from 2006/07, and now is 9.5% (2013/14). In contrast, the no show rate for family and nurse practitioners has increased since 2006/07 – increasing to 13.8%.

Figure 10 – Non urgent emergency room visits



Source: Stanton Territorial Health Authority.

What is being measured?

The proportion of emergency visits that are non-urgent, as defined by the Canadian Triage and Acuity Scale (CTAS) – CTAS categorizes the seriousness of a patient's condition in terms of the level of urgency required for their care.

Why is this of interest?

Inappropriate Emergency Room (ER) use makes it difficult to guarantee access for high emergency cases, decreases readiness to provide care, effects quality of care in the ER, and raises overall costs. Ensuring our resources are appropriately utilized and enabling patients to access the right services at the right time by the right provider will contribute to the sustainability of the system.

How are we doing?

At Stanton Territorial Hospital, the proportion of ER visits considered non-urgent has decreased from 12% in 2005/06 to a low of 2.5% in 2010/11 and leveled off at just over 7% in the last three fiscal years.

Key Activity 4 - Supplementary Health Programs

Description

The Department provides Supplementary Health Programs, in accordance with policy, to residents who meet eligibility criteria. Benefits include eligible prescription drugs, appliances, supplies, prostheses, and certain medical travel expenses. Specific benefit programs are:

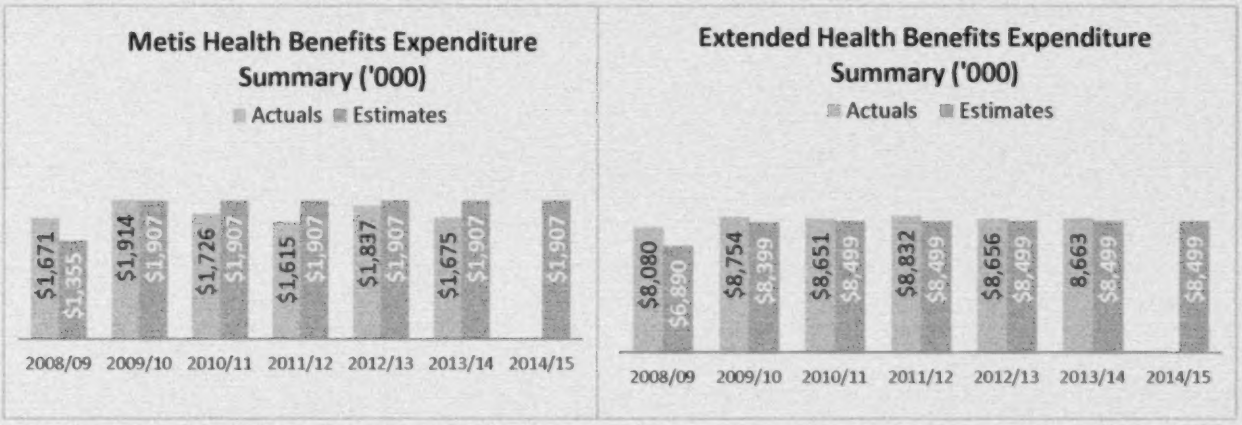
- Extended Health Benefits
- Métis Health Benefits
- Medical Travel Benefits
- Indigent Health Benefits

Departmental Highlights

GNWT Medical Travel Policy - It is important that patients have access to necessary and appropriate insured health services through a comprehensive and modern medical travel system. Work continues in 2014/15 to improve the medical travel experience for patients and provide for a sustainable, accountable, transparent and standardized medical travel program that is administered consistently across the NWT and that is responsive to the needs of NWT residents. In 2015/16, the Department will further modernize the program by including an appeal process, updating the medical travel data system and improving patient supports (escorts) and other program elements to ensure the best care is provided to all residents of the NWT.

GNWT Supplementary Health Coverage Policies - The Department will be exploring options for the restructuring of supplementary health coverage programs offered by the GNWT. Coverage is currently offered through the Extended Health Benefits Policy, Metis Health Benefits Policy, and an Indigent Health Benefits Policy. The Department also administers Non-Insured Health Benefits on behalf of the Federal Government. As part of this work, the Department will take into consideration calls for coverage for the working poor and for those with catastrophic drug costs.

Figure 11 – Expenditures for the Metis and Extended Health Benefits



Source: NWT Department of Health and Social Services.

What is being measured?

Expenditures for Metis and Extended Health Benefits

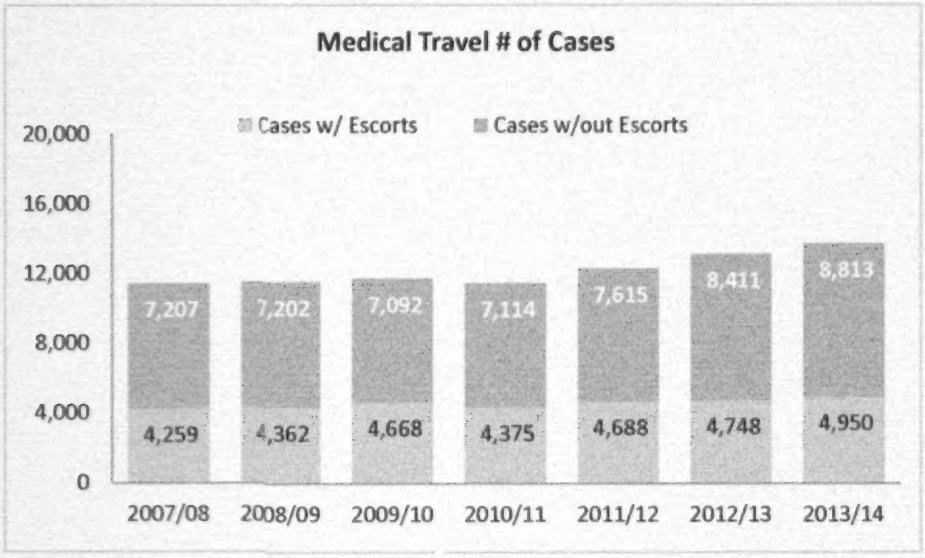
Why is this of interest?

The health care system is responsible for the delivery of health care services under the Canada Health Act. These services include primary health care (such as services of physicians and other health professionals) and care in hospitals. In addition, some groups are provided supplementary health benefits not covered by the Canada Health Act. These benefits include prescription drug coverage, dental coverage, supplies, prostheses and certain medical travel expenses.

How are we doing?

Expenditures on Metis Health Benefits have fluctuated between $1.6 and $1.9 million between 2008/09 and 2013/14. Expenditures on Extended Health Benefits have ranged between $8.1 and $8.8 million over the same five year period.

Figure 12 – Medical Travel Utilization



Source: Stanton Territorial Health Authority.

What is being measured?

The number of medical travel cases, with and without escorts, per fiscal year

Why is this of interest?

Medical travel is an important part of the health and social services system as it ensures that all residents have access to appropriate health care regardless of where they live. Monitoring medical travel is important to ensure we are appropriately meeting our clients' needs and managing costs where possible to ensure only medically necessary trips are taken and travel is maximized by linking numerous appointments.

How are we doing?

The number of medical travel cases has increased by 20% from 11,466 in 2007/08 to 13,763 in 2013/14. The proportion of cases with at least one approved escort has remained relatively steady, ranging between 36 and 40%. Seventy-two percent of medical travel trips are taken within the NWT, with the majority being from small communities to larger centres.

Key Activity 5 – Community Programs

Description

The Territorial Social Programs Division provides programming including child and family services, mental health and addictions, and the Office of the Public Guardian. Aspects of these programs are governed by the *Child and Family Services Act*, the *Adoption Act*, the *Mental Health Act*, and the *Public Guardian and the Trusteeship Act*. Services within these program areas are primarily delivered by Health and Social Service Authorities. The division's role involves setting standards, monitoring performance, and providing support to front line staff, supervisors, and managers.

Adult Continuing Care includes funding to Health and Social Services Authorities for long term care facilities, including group homes and residential care both inside and outside the NWT.

Community Social Services includes funding to Health and Social Services Authorities for community social service workers in the areas of prevention, assessment, early intervention, and counselling and treatment services related to children, youth and families. Funding is also provided for programs to enable individuals with special living requirements to stay in their homes as long as possible and services designed to assist living in the home.

Responding to Priorities

Mental Health and Addictions
"Ensure a fair and sustainable health care system by investing in ... enhancing addictions treatment programs" – 17th Legislative Assembly Caucus Priorities

The prevalence of addictions, and particularly alcohol abuse, has been a long-standing concern for NWT communities, and continues to be so in spite of numerous efforts over the years to tackle it. Yet there are many success stories, and inspiring leaders in all communities who have become important role models and helped others to deal with addictions issues. The Minister's Forum on Addictions and Community Wellness was established in 2011 to draw on this wisdom. The forum travelled to all regions of the NWT and met with people suffering from addictions, their families, government staff, teachers and RCMP officers, in an effort to find out what has worked at the community level.

Their report, *Healing Voices*, was delivered to the government in the spring of 2013 and identified key priorities based on community input. Among these priorities was the need for on-the-land healing programs rooted in Aboriginal culture and combining the wisdom of elders and

traditional knowledge with contemporary treatment modalities. Other primary recommendations included more programs for youth, improved access to a range of treatment programs to respond to individual needs, and more emphasis on celebrating successes.

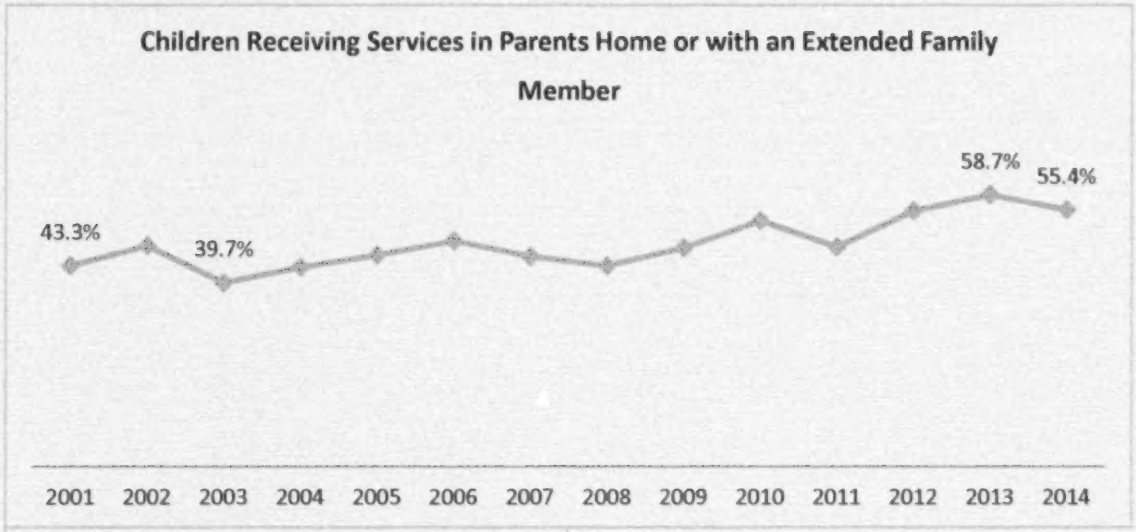
These recommendations informed our updated Addictions and Mental Health Action Plan, and resulted in new funding to support on-the-land healing programs. As land-based healing programs become more prevalent in the NWT and elsewhere, the lessons we learn from our own programs will help identify best practices for integrating aboriginal values and culture into efforts for supporting Aboriginal health and well-being.

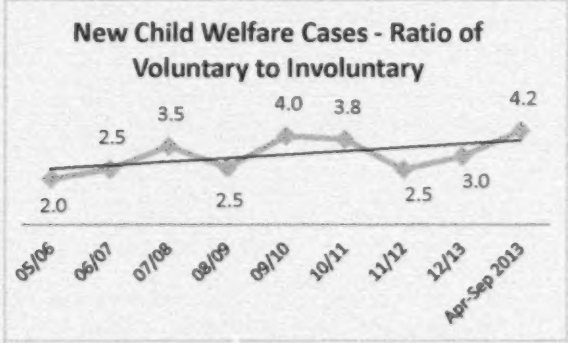
Child and Family Services

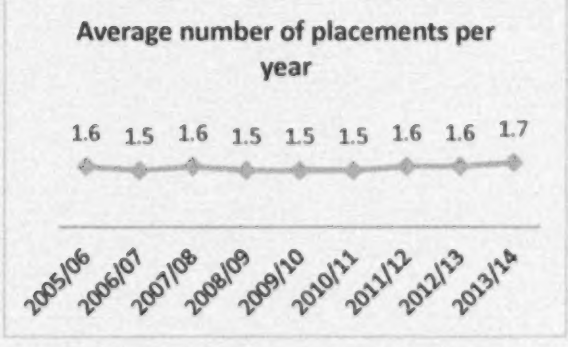
"Ensure a fair and sustainable health care system by investing in ... early childhood development" – 17th Legislative Assembly Caucus Priorities

The report of the Auditor General on Child and Family Services was tabled in the Legislative Assembly on March 4, 2014. The audit included 11 recommendations to improve accountability and service delivery to better assist children and families in our communities. The Department has accepted all of the recommendations and has developed a comprehensive action plan in response. During 2015/16 the Department will be focused on implementing the action plan. CEOs of the Authorities have been made Assistant Directors under the Act and have received statutory training on their roles and responsibilities under the Act. A new Child and Family Services Manual is being developed, and renewed training of frontline staff will continue.

Figure 13 – Child and Family Services







What are we measuring?

The proportion of children receiving services in the NWT who are receiving services at home or in the home of an extended family member, the ratio of new child welfare cases that are voluntary to involuntary and average number of placements per year.

Why is this of interest?

In order to ensure the best outcomes for children and their families, every effort is made to keep children in their home community and preferably in their own home or with a relative. It is also preferable that the services be on a voluntary basis (least intrusive manner) and that the number of placements per/child, per/year be minimized, in order to provide a stable environment for children in care.

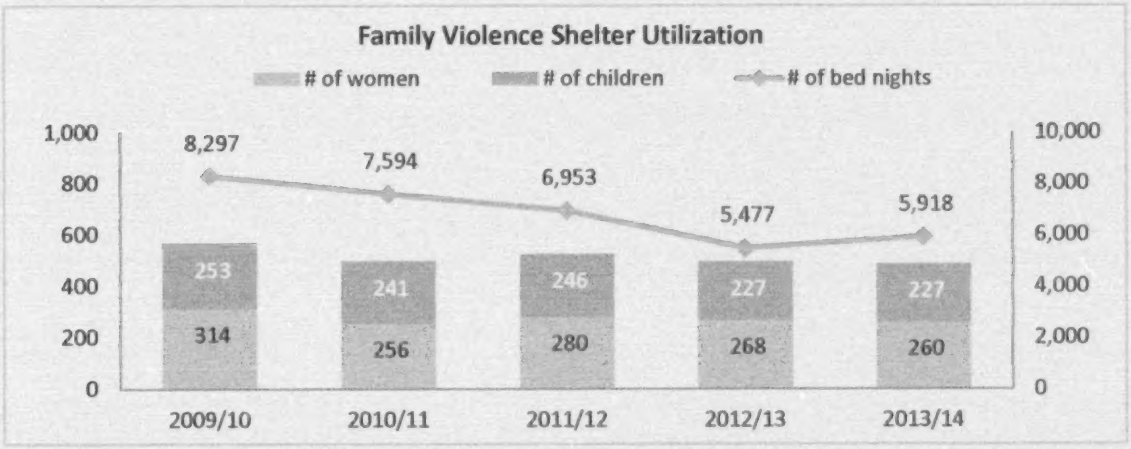
How are we doing?

As of March 31, 2014, there were 578 children receiving services. Approximately 55% of those children are receiving services in their home or with extended family.

Between 2005/06 and 2013/14, the ratio of new child welfare cases (receiving services) that are voluntary (plan of care, voluntary support or support services agreement) to involuntary (apprehended, permanent/temporary custody) has fluctuated. In 2013/14, the ratio was 4.2.

The average number of placements, per child, per year has remained constant, ranging from 1.5 in 2006/07 to 1.7 in 2013/14.

Figure 14 – Shelter Utilization



Source: NWT Department of Health and Social Services.

What is being measured?

The number of clients admitted to family violence shelters and the number of bed nights.

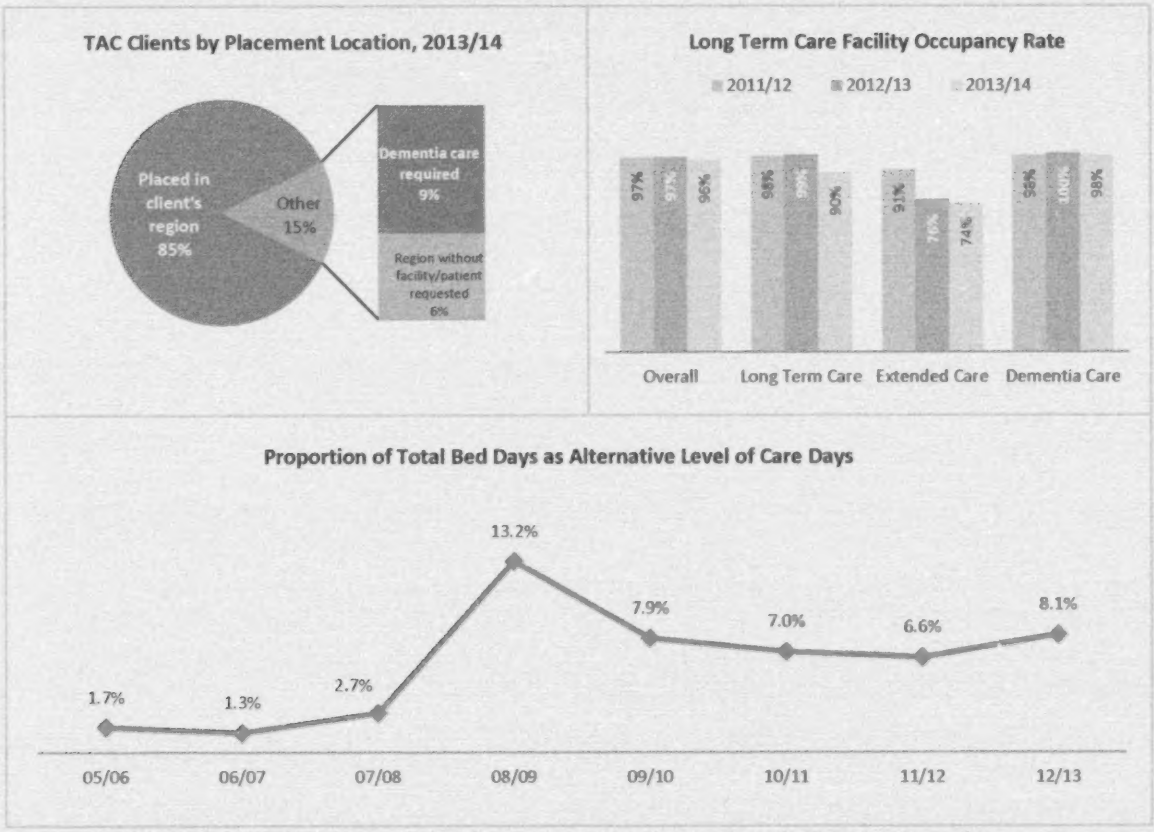
Why is this of interest?

Utilization of family violence shelters tells us how many clients are being admitted to residential services. This information supports the ongoing provision of family violence programming based on capacity and funding levels.

How are we doing?

Between 2009/10 and 2013/14, there has been a slight increase in the number of clients being admitted to the five NWT shelters. At the same time, there has been a decrease in the number of bed nights.

Figure 15 – Long term care and Alternative Level of Care



Sources: NWT Department of Health and Social Services and Canadian Institute for Health Information.

What is being measured?

The long term care occupancy rate and the percentage of total bed days as alternative level of care at the four acute care inpatient facilities in the NWT.

Why is this of interest?

The demand for long-term care (LTC) is growing as the NWT population ages. The more clients there are on the waitlist for LTC, the greater the pressure on other institutions and services. Clients eligible for LTC may end up in an acute care bed, or may suffer at home and not receive the most appropriate service when needed.

Alternative level of care (ALC) refers to those patients, who no longer need acute care services but are waiting to be discharged, from hospital, to access a setting more appropriate to their level of care needs. The lower the proportion of overall bed days as ALC days the more

efficiently our limited health care resources are being used. An efficient use of health care resources contributes to the sustainability of the health and social services system.

How are we doing?

The LTC occupancy rate has remained stable in the last three years – at a rate between 96% and 97% - above the 95% rate recommended. By better managing the occupancy rate, we can provide LTC beds for those who need them and prevent cases where clients end up in costly acute care beds. The percentage of total bed days as ALC days is increasing in NWT hospitals. However, a portion of this increase is due to better monitoring and tracking of acute care patients that become ALC patients.

Improving Accountability and Performance Measurement

As part of our commitment to accountability and performance monitoring, the following performance measures are being developed for Key Activity 5. We will begin publicly reporting on these measures in early 2015.

- Healthy Families - Monthly average number of a) families and b) children receiving services from the Healthy Families Program.
- Counselling Services Uptake - Monthly average number of clients of the Community Counselling Program.
- Mental Health Hospitalizations - Annual number of Mental Health hospital separations by diagnostic category.
- Addiction Treatment - Proportion of people referred to residential addictions treatment that complete the program.
- Child Placement Changes - Average number of total placements while in care.
- Child Placement Appropriateness - Proportion of Aboriginal children in care placed in an Aboriginal home.
- Child Safety - Proportion of children investigated as a result of a new allegation of abuse or neglect within one year following file closure.
- Family Safety - Proportion of families re-admitted to a shelter within one year of leaving.
- Substance Abuse - The percent of NWT population with reported substance abuse issues.

APPENDICES

Health and Social Services

Appendix I - Financial Information

Schedule 1 - Operations Expense Summary

Schedule 2 - Explanation of Proposed Adjustments to Operations Expenses in 2015-16

Schedule 3 - Major Revenue Changes: 2014-15 Main Estimates to 2015-16 Business Plan

Schedule 4 - Proposed Adjustments to Grants, Contributions & Transfers: 2014-15 Main Estimates to 2015-16 Business Plan

Appendix II - Human Resources Reconciliation

Schedule 1 - Position Changes: 2014-15 Main Estimates to 2015-16 Business Plan

Schedule 2 - Human Resources Statistics

Appendix III - Infrastructure Investments

Operations Expense Summary

Schedule 1

(thousands of dollars)

	2014-15 Main Estimates	PROPOSED ADJUSTMENTS: Sunsets	Initiatives	* Forced Growth	Internal Transfers	** Inter-Departmental Transfers and Other Adjustments	Amortization	2015-16 Business Plan
Directorate								
Directorate	1,635		8	34				1,677
Policy, Legislation and Communication	2,533	(111)	1,121	63	372			3,978
Corporate Planning, Reporting and Evaluation	2,207			38	(855)			1,390
Finance	1,750			64		(92)		1,722
Infrastructure Planning	424			14				438
Shared Services and Innovation	1,467		20		(381)			1,106
	10,016	(111)	1,149	213	(864)	(92)	-	10,311
Program Delivery Support								
Information Systems	7,847			484	(810)			7,521
Health and Social Services Human Resources	5,067			52	(16)			5,103
Health Services Administration	1,643			46				1,689
Territorial Health Services	5,056		46	65				5,167
Office of the Chief Public Health Officer	1,375			26	(371)			1,030
Population Health	3,122	(3)	(86)	69				3,102
Aboriginal Health and Community Wellness	2,600		78	45	3,156			5,879
HSS Authorities Administration	19,780	(972)	51	1,767	829			21,455
	46,490	(975)	89	2,554	2,788	-	-	50,946
Health Services Programs								
NWT Hospitals	98,650	(711)	973	2,407	(14)	(176)		101,129
NWT Health Centres	30,283	(20)	4	694		(119)		30,842
Out of Territories Hospitals	19,123							19,123
Physicians Inside the NWT	43,655			983	(20)	(326)		44,292
Physicians Outside the NWT	5,333							5,333
Equipment Evergreening	1,552							1,552
Amortization	10,411							10,411
	209,007	(731)	977	4,084	(34)	(621)	-	212,682
Supplementary Health Programs								
Indigent Health Benefits	115							115
Metis Health Benefits	1,907							1,907
Extended Health Benefits	8,449							8,449
Medical Travel Benefits	16,829			21				16,850
	27,300	-	-	21	-	-	-	27,321
Community Programs								
Child and Family Services	24,781		729	54	(1,766)			23,798
Mental Health and Addictions	4,859		8	20	(124)			4,763
Adult Continuing Care Services	34,146	(604)	618	844		(171)		34,633
Community Social Services	34,470			944		(31)		35,383
Amortization	860							860
	99,116	(604)	1,355	1,662	(1,890)	(202)	-	99,437
TOTAL DEPARTMENT	391,929	(2,421)	3,570	8,534	-	(915)	-	400,697

** Forced Growth amounts include Collective Bargaining increases.*

*** This category includes departmental reductions.*

(thousands of dollars)

		PROPOSED ADJUSTMENTS				
	Explanation of Proposed Adjustments	Sunsets	Initiatives	* Forced Growth	Internal Transfers	** Inter-Departmental Transfers and Other Adjustments
Directorate						
Directorate	Clinical Governance: Standards & Monitoring - Collective Agreement Increases		8			
	Collective Agreement			34		
Policy, Legislation and Communication	Re-alignment of resources				372	
	Health Information Act	(111)				
	French Language Communications & Services		1,109			
	HSS Accessing Increased CHT Dollars - Collective Agreement Increases		12			
	Collective Agreement			63		
Corporate Planning, Reporting and Evaluation	Re-alignment of resources				(855)	
	Collective Agreement			38		
Finance	Collective Agreement			64		
	Final Phase of Procurement Shared Services					(84)
	Implementation of Financial Shared Services					(8)
Infrastructure Planning	Collective Agreement			14		
Shared Services and Innovation	Re-alignment of resources				(381)	
	HSS Accessing Increased Canada Health Transfer Dollars - Collective Agreement Increases		20			
		(111)	1,149	213	(864)	(92)
Program Delivery Support						
Information Systems	Re-alignment of resources				(810)	
	Licensing & Maintenance - Inflation			369		
	Collective Agreement			115		
Health and Social Services Human Resources	Re-alignment of resources				(16)	
	Collective Agreement			52		
Health Services Administration	Collective Agreement			46		
Territorial Health Services	Clinical Governance - Collective Agreement Increases		4			
	Midwifery Program		42			
	Collective Agreement			53		
	Non-Government Organizations			12		
Office of the Chief Public Health Officer	Re-alignment of resources				(371)	
	Contract with NWT Medcial Association			26		
Aboriginal Health and Community Wellness	Re-alignment of resources				3,156	
	Reallocation of the $1.67M: ECD Action Plan		78			
	Collective Agreement			45		
Population Health	Sahtu Oil and Gas - EHO	(3)				
	Reallocation of the $1.67M: ECD Action Plan		(86)			
	Collective Agreement			69		
HSS Authorities Administration	Re-alignment of resources				829	
	TSC Implementation at HSS Authorities	(972)				
	Reallocation of the $1.67M: ECD Action Plan		8			
	Med-Response - Collective Agreement Increases		29			
	EMR - Collective Agreement Increases		14			
	Collective Agreement			531		
	Microsoft Licensing			1,129		
	Licensing & Maintenance - Inflation			107		
		(975)	89	2,554	2,788	-

		(thousands of dollars)				
		PROPOSED ADJUSTMENTS				
	Explanation of Proposed Adjustments	Sunsets	Initiatives	* Forced Growth	Internal Transfers	** Inter-Departmental Transfers and Other Adjustments
Health Services Programs						
NWT Hospitals	Re-alignment of resources				(14)	
	Vaccination Programs	(11)				
	Referred-out Diagnostic Laboratory Services	(700)				
	Northern Alberta Renal Program - Collective Agreement Increase		5			
	Midwifery Program		964			
	HSS Accessing Increased CHT Dollars - Collective Agreement Increases		4			
	Collective Agreement			1,976		
	STHA Dietary, Laundry, Housekeeping			95		
	Supplies			176		(176)
	Callback and Standby Pay			9		
	Relief Costs in Essential Services			151		
NWT Health Centres	Vaccination Programs	(20)				
	Shared Services & Innovation Division: Collective Agreement Increases		4			
	Collective Agreement			548		
	Supplies			119		(119)
	Callback and Standby Pay			27		
Physicians Inside the NWT	Re-alignment of resources				(20)	
	Collective Agreement			134		
	Contract with NWT Medcial Association			849		
	Transfer Lease funding to PWS					(326)
		(731)	977	4,084	(34)	(621)
Supplementary Health Programs						
Medical Travel Benefits	Collective Agreement			21		
		-	-	21	-	-
Activity 5 -						
Child and Family Services	Re-alignment of resources				(1,766)	
	Early Intervention Coordinators		729			
	Collective Agreement			54		
Mental Health and Addictions	Re-alignment of resources				(124)	
	Promotion & Prevention - HQ - Collective Agreement Increases		8			
	Collective Agreement			20		
Adult Continuing Care Services	Continuum of Care Supports	(604)	618			
	Collective Agreement			304		
	Relief Costs in Essential Services			27		
	Non-Government Organizations			313		(171)
Community Social Services	Collective Agreement			885		
	Non-Government Organizations			59		(31)
		(604)	1,355	1,662	(1,890)	(202)
TOTAL DEPARTMENT		(2,421)	3,570	8,534	-	(915)

** Forced Growth amounts include Collective Bargaining increases.*

*** This category includes departmental reductions.*

(thousands of dollars)

	PROPOSED ADJUSTMENTS				
	2014-15 Main Estimates	2015-16 Business Plan	Increase (Decrease) Proposed	Increase (Decrease) %	Explanation of Increases (Decreases) that are 10% or Greater
TRANSFER PAYMENTS					
Federal Cost-shared	29,416	30,004	588	2.0	2% increase as per agreement with AANDC
Capital Transfers	381	762	381	100.0	20% of projected funding from CanadaHealth Infoway
	29,797	**30,766**	**969**	**3.3**	
GENERAL REVENUES					
Regulatory Revenue	315	315	-	-	
Program	14,500	17,240	2,740	18.9	
Grants in Kind	443	443	-	-	
	15,258	**17,998**	**2,740**	18.0	
TOTAL REVENUE	**45,055**	**48,764**	**3,709**	**8.2**	

(thousands of dollars)

Key Activity	Explanation of Proposed Adjustments	2014-15 Main Estimates	PROPOSED ADJUSTMENTS Sunsets	Initiatives	* Forced Growth	Internal Transfers	Inter-Departmental Transfers and Other Adjustments	2015-16 Business Plan
Directorate								
Tlicho Cultural Co-ordinator		35	-	-	-	-	-	35
Anti-Poverty Strategy & Framework	Re-alignment of resources	650	-	-	-	(650)	-	-
French Language Communications & Services		-	-	856	-	-	-	856
		685	**-**	**856**	**-**	**(650)**	**-**	**891**
Program Delivery Support								
Professional Development, Recruitment and Retention (HSS Human Resources)		2,701	-	-	-	-	-	2,701
Territorial Health Services	Non-Government Organizations	761	-	-	12	-	-	773
Office of the Chief Public Health Officer	Re-alignment of resources	11	-	-	-	(11)	-	-
Aboriginal Health and Community Wellness — Authorities	Collective Agreement	448	-	-	26		-	474
Aboriginal Health and Community Wellness — Department	Re-alignment of resources	715	-	-		174	-	889
Anti-Poverty Strategy & Framework	Re-alignment of resources	-	-	-	-	650	-	650
Healthy Choices	Re-alignment of resources	-	-	-	-	350	-	350
Healthy Families — Department	Re-alignment of resources	-	-	-	-	1,042	-	1,042
HSS Authorities Administration	Re-alignment of resources	19,780	-	-	-	829	-	-
	TSC Implementation at HSS Authorities	-	(972)	-	-	-	-	-
	Reallocation of the $1.67M: ECD Action Plan	-	-	8	-	-	-	-
	Med-Response - Collective Agreement Increases	-	-	29	-	-	-	-
	EMR - Collective Agreement Increases	-	-	14	-	-	-	-
	Collective Agreement	-	-	-	531	-	-	-
	Microsoft Licensing	-	-	-	1,129	-	-	-
	Licensing & Maintenance - Inflation	-	-	-	107	-	-	-
								21,455
		24,416	**(972)**	**51**	**1,805**	**3,034**	**-**	**28,334**

(thousands of dollars)

Key Activity	Explanation of Proposed Adjustments	2014-15 Main Estimates	PROPOSED ADJUSTMENTS Sunsets	Initiatives	* Forced Growth	Internal Transfers	Inter-Departmental Transfers and Other Adjustments	2015-16 Business Plan
Health Services Programs								
Grants								
Medical Professional Development		40	-	-	-	-	-	40
Contributions								
Hospital Services	Re-alignment of resources	87,752	-	-	-	(14)	-	-
	Vaccination Programs	-	(11)	-	-	-	-	-
	Referred-out Diagnostic Laboratory Services	-	(700)	-	-	-	-	-
	Northern Alberta Renal Program - Collective Agreement Increases	-	-	5	-	-	-	-
	Midwifery Program	-	-	964	-	-	-	-
	HSS Accessing Increased CHT Dollars - Collective Agreement Increases	-	-	4	-	-	-	-
	Collective Agreement	-	-	-	1,976	-	-	-
	STHA Dietary, Laundry, Housekeeping	-	-	-	95	-	-	-
	Supplies	-	-	-	176	-	(176)	-
	Callback and Standby Pay	-	-	-	9	-	-	-
	Relief Costs in Essential Services	-	-	-	151	-	-	-
								90,231
Health Centres	Vaccination Programs	30,283	(20)	-	-	-	-	-
	HSS Accessing Increased Canada Health Transfer Dollars - Collective Agreement Increases	-	-	4		-	-	-
	Collective Agreement	-	-	-	548	-	-	-
	Supplies	-	-	-	119	-	(119)	-
	Callback and Standby Pay	-	-	-	27	-	-	-
								30,842
Physician Sevices to NWT Residents	Re-alignment of resources	39,586	-	-	-	(20)	-	-
	Collective Agreement	-	-	-	134	-	-	-
	Contract with NWT Medcial Association	-	-	-	812	-	-	-
	Transfer Lease funding to PWS	-	-	-	-	-	(326)	-
								40,186
Equipment Evergreening		700	-	-	-	-	-	700
		158,361	**(731)**	**977**	**4,047**	**(34)**	**(621)**	**161,999**
Supplementary Health Programs								
Medical Travel Benefits	Collective Agreement	16,829	-	-	21	-	-	16,850
		16,829	**-**	**-**	**21**	**-**	**-**	**16,850**

(thousands of dollars)

Key Activity		Explanation of Proposed Adjustments	2014-15 Main Estimates	PROPOSED ADJUSTMENTS Sunsets	Initiatives	* Forced Growth	Internal Transfers	Inter-Departmental Transfers and Other Adjustments	2015-16 Business Plan
Community Programs									
Grants									
Rockhill Apartments			443	-	-	-	-	-	443
Contributions									
Health Awareness, Activities and Education	Healthy Families - Department	Re-alignment of resources	750	-	-	-	(750)	-	-
	Healthy Families - Authority	Re-alignment of resources	1,278	-	-	-	(292)	-	986
	Non-Government Organizations	Re-alignment of resources	291	-	-	-	(163)	-	128
Children's Services	Intervention (Protective) Services	Early Intervention Coordinators	962	-	729	-	-	-	-
		Collective Agreement	-	-	-	4	-	-	-
									1,695
	Foster Care		7,689	-	-	-	-	-	7,689
	Residential Care		3,675	-	-	-	-	-	3,675
Mental Health and Addictions		Re-alignment of resources	2,313	-	-	-	(150)	-	2,163
Residential Care - Elderly & Persons with Disabilities		Continuum of Care Supports	23,929	(604)	618	-	-	-	-
		Collective Agreement	-	-	-	297	-	-	-
		Relief Costs in Essential Services	-	-	-	27	-	-	-
		Non-Government Organizations	-	-	-	313	-	(171)	
									24,409
Community Services	Social Services	Collective Agreement	20,779	-	-	607	-	-	21,386
	Alcohol and Drugs	Non-Government Organizations	835	-	-	87	-	(21)	901
	Family Violence		2,912	-	-	-	-	-	2,912
	Community Wellness	Collective Agreement	1,813	-	-	25	-	-	-
		Non-Government Organizations	-	-	-	18	-	(10)	-
									1,846
	Homecare	Collective Agreement	6,035	-	-	207	-	-	6,242
			73,704	**(604)**	**1,347**	**1,585**	**(1,355)**	**(202)**	**74,475**
TOTAL DEPARTMENT			**273,995**	**(2,307)**	**3,231**	**7,458**	**995**	**(823)**	**282,549**

Position Changes: 2014-15 Main Estimates to 2015-16 Business Plan

Schedule 1

		REGION / AREA							
	Community	Yellowknife / HQ	North Slave	Tli Cho	South Slave	Deh Cho	Sahtu	Beaufort-Delta	TOTAL
2014-15 Main Estimates		153	-	-	1	1	2	20	177
Initiatives									
French Language Co-ordinator	Yellowknife	1	-	-	-	-	-	-	1
Bilingual Health Care Co-ordinator	Inuvik	-	-	-	-	-	-	1	1
		1	-	-	-	-	-	1	2
Increase (decrease)		1	-	-	-	-	-	1	2
Total 2015-16 Business Plan		154	-	-	1	1	2	21	179

Position Changes: 2014-15 Main Estimates to 2015-16 Business Plan

Schedule 1

		REGION / AREA							
	Community	Yellowknife / HQ	North Slave	Til Cho	South Slave	Deh Cho	Sahtu	Beaufort-Delta	TOTAL
2014-15 Main Estimates		-	566	106	319	95	72	234	1,392
Restatements									
French Language Co-ordinator(PT)	Yellowknife(STHA)	-	1	-	-	-	-	-	1
French Language Co-ordinator(PT)	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
French Language Services Coordinator(PT)	Hay River	-	-	-	1	-	-	-	1
French Language Co-ordinator(PT)	Fort Smith	-	-	-	1	-	-	-	1
2014-15 Restated Main Estimates		-	568	106	321	95	72	234	1,396
Sunsets		-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-
Initiatives									
French Languages									
French Language Co-ordinator(PT)	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
System Navigator - French Language	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
French Language Co-ordinator(PT)	Yellowknife(STHA)	-	(1)	-	-	-	-	-	(1)
System Navigator - French Language	Yellowknife(STHA)	-	1	-	-	-	-	-	1
French Language Services Coordinator(PT)	Hay River	-	-	-	(1)	-	-	-	(1)
System Navigator - French Language	Hay River	-	-	-	1	-	-	-	1
French Language Co-ordinator(PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
System Navigator - French Language	Fort Smith	-	-	-	1	-	-	-	1
Medical Interpreter	Yellowknife(STHA)	-	1	-	-	-	-	-	1
System Navigator - French Language	Inuvik	-	-	-	-	-	-	1	1
Midwifery									
Midwife	Inuvik	-	-	-	-	-	-	1	1
Midwife	Inuvik	-	-	-	-	-	-	1	1
Midwife	Inuvik	-	-	-	-	-	-	1	1
Midwife	Inuvik	-	-	-	-	-	-	1	1
Admin Support - Midwife(PT)	Inuvik	-	-	-	-	-	-	1	1
ECD Action Plan									
Early Intervention Coordinator	Inuvik	-	-	-	-	-	-	1	1
Early Intervention Coordinator	Norman Wells	-	-	-	-	-	1	-	1
Early Intervention Coordinator	Fort Simpson	-	-	-	-	1	-	-	1
Early Intervention Coordinator	Behchoko	-	-	1	-	-	-	-	1
Early Intervention Coordinator	Fort Smith	-	-	-	1	-	-	-	1
Early Intervention Coordinator	Hay River	-	-	-	1	-	-	-	1
		-	1	1	2	1	1	7	13
Forced Growth		-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-
Internal Transfers		-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-
Internal Reallocation									
Community Health Nurse	Sachs Harbour	-	-	-	-	-	-	(1)	(1)
Social Worker	Inuvik	-	-	-	-	-	-	(1)	(1)
Home Support Worker	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
Registered Dietician	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Clinic Administrative Supervisor(PT)	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
Clinic Administrative Supervisor	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Administration Assistant- Exec	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Administrative Assistant	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Entry Level Family & Community SW	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
Homecare Nurse	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Home Support Worker	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Diabetes Educator Dietician(PT)	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
Diabetes Educator Dietician	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Diabetes Nurse Educator - LPN (PT)	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
Diabetes Nurse Educator - LPN	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Home Support Worker	Yellowknife(YHSSA)	-	(1)	-	-	-	-	-	(1)
Admin Support Outpatient Psychiatry	Yellowknife(YHSSA)	-	1	-	-	-	-	-	1
Advanced Emergency Medical Co-ordinators	Yellowknife(STHA)	-	1	-	-	-	-	-	1
Advanced Emergency Medical Co-ordinators	Yellowknife(STHA)	-	1	-	-	-	-	-	1
RN - Northern Options for Women(PT)	Yellowknife(STHA)	-	1	-	-	-	-	-	1
Unit Clerk - Northern Options for Women(PT)	Yellowknife(STHA)	-	1	-	-	-	-	-	1
Unit Clerk - Northern Options for Women	Yellowknife(STHA)	-	(1)	-	-	-	-	-	(1)
Diagnostic Services Clerk(PT)	Yellowknife(STHA)	-	1	-	-	-	-	-	1
Diagnostic Services Clerk	Yellowknife(STHA)	-	(1)	-	-	-	-	-	(1)
Volunteer Services Co-ordinator(PT)	Yellowknife(STHA)	-	1	-	-	-	-	-	1
Oncology Nurse Navigator(PT)	Yellowknife(STHA)	-	(1)	-	-	-	-	-	(1)
OR - RN First Assist	Yellowknife(STHA)	-	1	-	-	-	-	-	1
Laundry Aide	Hay River	-	-	-	(1)	-	-	-	(1)
Laundry Aide(PT)	Hay River	-	-	-	1	-	-	-	1
Laundry Aide(PT)	Hay River	-	-	-	1	-	-	-	1
Grad Social Worker III	Hay River	-	-	-	1	-	-	-	1
Executive Assistant (PT)	Hay River	-	-	-	(1)	-	-	-	(1)
Physician Recruiter (PT)	Hay River	-	-	-	(1)	-	-	-	(1)
Physician Recruiter/Physician Recruiter	Hay River	-	-	-	1	-	-	-	1
Nurse Educator	Hay River	-	-	-	1	-	-	-	1
Med/Surg & Dialysis Registered Nurse(PT)	Hay River	-	-	-	1	-	-	-	1
Med/Surg & Dialysis Registered Nurse	Hay River	-	-	-	(1)	-	-	-	(1)

Position Changes: 2014-15 Main Estimates to 2015-16 Business Plan

Schedule 1

		REGION / AREA							
	Community	Yellowknife / HQ	North Slave	Tli Cho	South Slave	Deh Cho	Sahtu	Beaufort-Delta	TOTAL
Clinic Assistant(PT)	Hay River	-	-	-	(1)	-	-	-	(1)
Clinic Assistant	Hay River	-	-	-	1	-	-	-	1
Medical Radiology/Sonography Technologist	Hay River	-	-	-	1	-	-	-	1
Public Health Nurse(PT)	Hay River	-	-	-	1	-	-	-	1
Community Health RN Supervisor	Hay River	-	-	-	(1)	-	-	-	(1)
Community Health RN Supervisor(PT)	Hay River	-	-	-	1	-	-	-	1
Clinic Assistant(PT)	Hay River	-	-	-	(1)	-	-	-	(1)
Registered Nurse - Graduate Program	Hay River	-	-	-	1	-	-	-	1
Admin Assistant - Accomodation Position(PT)	Hay River	-	-	-	(1)	-	-	-	(1)
Client Care Co-ordinator	Hay River	-	-	-	(1)	-	-	-	(1)
Quality Improvement Coordinator	Hay River	-	-	-	(1)	-	-	-	(1)
Nurse Practitioner	Hay River	-	-	-	1	-	-	-	1
Nurse Practitioner	Hay River	-	-	-	1	-	-	-	1
Home Support Worker(PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Resident Care Aide	Fort Smith	-	-	-	(1)	-	-	-	(1)
Resident Care Aide (PT)	Fort Smith	-	-	-	1	-	-	-	1
Resident Care Aide	Fort Smith	-	-	-	(1)	-	-	-	(1)
Resident Care Aide (PT)	Fort Smith	-	-	-	1	-	-	-	1
Resident Care Aide	Fort Smith	-	-	-	1	-	-	-	1
Resident Care Aide (PT)	Fort Smith	-	-	-	1	-	-	-	1
Resident Care Aide (PT)	Fort Smith	-	-	-	1	-	-	-	1
Resident Care Aide	Fort Smith	-	-	-	(1)	-	-	-	(1)
Resident Care Aide (PT)	Fort Smith	-	-	-	1	-	-	-	1
Rehabilitation Therapist LOA	Fort Smith	-	-	-	(1)	-	-	-	(1)
Facilities Maintenance	Fort Smith	-	-	-	(1)	-	-	-	(1)
RN - Dialysis(PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
RN - Dialysis	Fort Smith	-	-	-	1	-	-	-	1
LPN-Relief/LPN NEW	Fort Smith	-	-	-	1	-	-	-	1
Community Dietitian (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Registered Midwife (PT)	Fort Smith	-	-	-	1	-	-	-	1
Registered Midwife (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Physiotherapist	Fort Smith	-	-	-	1	-	-	-	1
Pharmacist (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Medical Social Worker (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Medical Social Worker (PT)	Fort Smith	-	-	-	1	-	-	-	1
Registered Nurse	Fort Smith	-	-	-	1	-	-	-	1
Registered Nurse	Fort Smith	-	-	-	1	-	-	-	1
Registered Nurse	Fort Smith	-	-	-	1	-	-	-	1
Resident Care Aide (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Registration Area Pool (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Registered Nurse (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Registered Nurse (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Registered Nurse	Fort Smith	-	-	-	(1)	-	-	-	(1)
Admin Support - Midwifery Program (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
Admin Assistant (PT)	Fort Smith	-	-	-	(1)	-	-	-	(1)
NP Nurse Practitioner (PT)	Fort Smith	-	-	-	1	-	-	-	1
Personal Support Worker - HC	Fort Providence	-	-	-	-	1	-	-	1
Activity Coordinator	Fort Providence	-	-	-	-	(1)	-	-	(1)
Activity Coordinator (PT)	Fort Providence	-	-	-	-	1	-	-	1
Asst. Cook (PT)	Fort Simpson	-	-	-	-	(1)	-	-	(1)
Asst. Cook	Fort Simpson	-	-	-	-	1	-	-	1
Dietary Aide (PT)	Fort Simpson	-	-	-	-	1	-	-	1
Dietary Aide (PT)	Fort Simpson	-	-	-	-	1	-	-	1
Asst. Cook	Fort Simpson	-	-	-	-	(1)	-	-	(1)
CSW III	Fort Simpson	-	-	-	-	1	-	-	1
Home Support Worker (PT)	Deline	-	-	-	-	-	(1)	-	(1)
Public Health Nurse	Norman Wells	-	-	-	-	-	(1)	-	(1)
Patient Referral/Medical Travel Officer	Norman Wells	-	-	-	-	-	(1)	-	(1)
Administraton Assistant	Norman Wells	-	-	-	-	-	1	-	1
Healthy Families & Community Wellness Worker	Norman Wells	-	-	-	-	-	1	-	1
Community Health Representative	Norman Wells	-	-	-	-	-	1	-	1
Home Support Worker (PT)	Tulita	-	-	-	-	-	(1)	-	(1)
Addictions Counsellor	Behchoko	-	-	(1)	-	-	-	-	(1)
Clinical Care Coordinator	Behchoko	-	-	1	-	-	-	-	1
Community Wellness Worker Trainee	Behchoko	-	-	(1)	-	-	-	-	(1)
Diabetic Worker	Behchoko	-	-	(1)	-	-	-	-	(1)
IT Technician	Behchoko	-	-	1	-	-	-	-	1
Clinical Supervisor	Behchoko	-	-	1	-	-	-	-	1
Home Visitor	Behchoko	-	-	(1)	-	-	-	-	(1)
Individual/Family Councellor	Behchoko	-	-	1	-	-	-	-	1
Manager, Risk Management	Behchoko	-	-	1	-	-	-	-	1
New Clerk/Interpreter	Behchoko	-	-	1	-	-	-	-	1
Program Coordinator	Behchoko	-	-	(1)	-	-	-	-	(1)
		-	7	1	-	3	(1)	(2)	8
Increase (decrease)		-	8	2	2	4	-	5	21
Total 2015-16 Business Plan		-	576	108	323	99	72	239	1,417

	2014-15	%	2013-14	%	2012-13	%	2011-12	%
All Employees	**164**	**100.0%**	**155**	**100.0%**	**154**	**100.0%**	**132**	**100.0%**
Indigenous Employees	62	37.8%	61	39.4%	56	36.4%	46	34.8%
Aboriginal	35	21.3%	33	21.3%	27	17.5%	23	17.4%
Non-Aboriginal	27	16.5%	28	18.1%	29	18.8%	23	17.4%
Non-Indigenous Employees	102	62.2%	94	60.6%	98	63.6%	86	65.2%
Male	49	29.9%	46	29.7%	41	26.6%	33	25.0%
Female	115	70.1%	109	70.3%	113	73.4%	99	75.0%
Senior Management	**13**	**9.8%**	**15**	**9.7%**	**9**	**5.8%**	**9**	**6.8%**
Indigenous Employees	5	38.5%	5	33.3%	3	33.3%	3	33.3%
Aboriginal	3	23.1%	3	20.0%	1	11.1%	1	11.1%
Non-Aboriginal	2	15.4%	2	13.3%	2	22.2%	2	22.2%
Non-Indigenous Employees	8	61.5%	10	66.7%	6	66.7%	6	66.7%
Male	4	30.8%	6	40.0%	3	33.3%	3	33.3%
Female	9	69.2%	9	60.0%	6	66.7%	6	66.7%
Non-Traditional Occupations	**18**	**13.6%**	**18**	**11.6%**	**10**	**6.5%**	**14**	**10.6%**
Indigenous Employees	1	5.6%	2	11.1%	2	20.0%	1	7.1%
Aboriginal		0.0%		0.0%		0.0%		0.0%
Non-Aboriginal	1	5.6%	2	11.1%	2	20.0%	1	7.1%
Non-Indigenous Employees	17	94.4%	16	88.9%	8	80.0%	13	92.9%
Male	14	77.8%	15	83.3%	6	60.0%	9	64.3%
Female	4	22.2%	3	16.7%	4	40.0%	5	35.7%

*Note:2012-2014 PeopleSoft Information as of March 31 / 2015 PeopleSoft Information as of June 30

Appendix III - Infrastructure Investments

The Department of Health and Social Services through the GNWT Corporate Capital Planning Process has made a significant investment in the Health and Social Services Infrastructure in the past four years.

Planning studies have been completed for Jean Marie River, Lutsel K'e, and Trout Lake. Planning is currently underway for the Fort Simpson Health Center, the Extended Care addition for Woodland Manor in Hay River, the Tulita Health Center Replacement, and the Yellowknife Extended Care facility. The planning for the replacement of the Stanton Territorial Hospital is complete and the project is now moving forward as a Public Private Partnership.

Planned Activities – 2015-16

Planning Studies

We will complete planning studies for the following proposed projects, to bring forward for consideration for inclusion in the GNWT Infrastructure Plan:

- Avens pavilion long-term care centre;
- Fort Simpson Health and Social Services Centre;
- Tulita Health and Social Services Centre;
- Yellowknife Extended Care Facility; and
- Additional planning studies will be proposed as part of the Department's initiative to refocus its ongoing capital planning.

Medical Equipment

To continue to deliver safe and efficient quality health services, facilities across the NWT require ongoing medical equipment replacement and investment. The Biomedical Engineering unit within Stanton maintains more than 2,500 pieces of biomedical equipment across the North (valued at over $30M) and is responsible for assessing and forecasting needs on behalf of all the Authorities.

Health Centre – Hay River

The design build contract was awarded in July 2012. The operational planning, functional programming, and design are complete for the new Health Centre. Construction started in March 2013 and is underway. Final scheduling is being developed. Furniture, fixtures and equipment are being finalized for procurement, and operational and transitional planning is scheduled to develop in fall 2014. The Health Centre is expected to officially open in late 2015/2016.

Long Term Care Facility – Jimmy Erasmus Seniors Home in Behchokó

Replace the existing 8-bed facility with a new 18-bed facility based on the Department's Long Term Care facility prototype. Construction began in May 2012. Phase 1 was completed in late summer 2014 and Phase 2 will be complete April 2015.

Long Term Care Facility – Woodland Manor in Hay River

Expansion planning for Woodland Manor is underway. The Operational Plan and Functional Program are nearing completion. A construction Request for Proposals (RFP) will be released in the fall of 2014 for the design and construction of the 10-bed expansion. This expansion will accommodate the Long Term Care residents that are currently located at H. H. Williams Hospital and must be relocated due to the decommissioning of H. H. Williams and the opening of the new Health Centre in Hay River.

Health and Social Services Centre and Long-Term Care Facility – Norman Wells

Replace the existing Health Centre based on the Department's prototypes developed for Level B/C Health and Social Services Centres and Long Term Care facilities. The Operational Plan and Functional Programming has been completed and schematic design has been approved. Construction started in May 2013 and is still in early stages of site preparation for foundation placement. Final completion is anticipated in 2015/16.

Health and Social Services Centre – Fort Providence

Replace the existing facility based on the Department's Level B facility prototype. Construction began in fall 2013 will be complete and ready for occupancy in late January 2015.

Health and Social Services Centre – Fort Resolution

Replace the existing facility based on the Department's Level B facility prototype. An RFP for Design Build is expected in fall 2014. Construction is expected to begin in spring 2015 with projected completion in 2017.

Stanton Territorial Hospital Renewal - Yellowknife

Planning for the Stanton Territorial Hospital was completed in December of 2013. In March 2014 it was determined in accordance with the GNWT P3 policy that the Stanton Redevelopment should proceed as a P3 project. A request for proposal will be issued in 2014 with finial close expected in 2015. Once a contract is successfully signed construction is anticipated to take five years.